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In the Supreme Court of the United States

OCTOBER TERM, 1985

MARGARET M. HECKLER, SECRETARY OF HEALTH AND HUMAN SERVICES, ET AL., PETITIONERS

v.

MICHIGAN ACADEMY OF FAMILY PHYSICIANS, ET AL.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

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QUESTION PRESENTED

Whether, notwithstanding the preclusions of review in 42 U.S.C. 1395ff and 405(h), the district court properly exercised jurisdiction under 28 U.S.C. 1331 to entertain respondents' challenge to a regulation affecting the amount of benefits payable for medical services under Part B of the Medicare Program.

PARTIES TO THE PROCEEDING

The petitioners are Margaret M. Heckler, Secretary of Health and Human Services, and Blue Cross and Blue Shield of Michigan, an insurance carrier that has contracted with the Secretary pursuant to 42 U.S.C. 1395u to administer the Part B Medicare Program in Michigan on her behalf.

The respondents are: (1) the Michigan Academy of Family Physicians, a nonprofit association of family physicians in Michigan; (2) Lester Webb and Charles Farber, family physicians who are eligible for specialist certification under the standards of the American Board of Family Practice but who have not been certified as specialists under those standards; (3) Glenn House, a family physician certified as a specialist under the standards of the American Board of Family Practice; and (4) Carol A. Diedrich, a resident of Michigan and a Medicare Part B recipient whose treating physician, Philip Lange, is a family physician who is neither Board-certified nor Board-eligible.

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PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

The Solicitor General, on behalf of the Secretary of Health and Human Services and Blue Cross and Blue Shield of Michigan, petitions for a writ of certiorari to review the judgment of the United States Court of Appeals for the Sixth Circuit in this case.

OPINIONS BELOW

The original opinion of the court of appeals, dated February 23, 1984 (App., *infra*, 1a-15a), is reported at 728 F.2d 326. The November 5, 1984 order of the court of appeals (App., *infra*, 16a), following the remand by this Court, is reported at 751 F.2d 809, and the March 19, 1985 order of the court of appeals on respondents' petition for rehearing (App., *infra*, 17a-22a) is reported at 757 F.2d 91. The opinion of the district court (App., *infra*, 23a-33a) is reported at 502 F. Supp. 751.

JURISDICTION

The judgment of the court of appeals was entered on March 19, 1985. The Secretary's timely petition for re-

hearing was denied on May 30, 1985 (App., *infra*, 35a). The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATUTORY PROVISIONS AND REGULATION INVOLVED

28 U.S.C. 1331; relevant provisions of Sections 205(h), 1842 and 1869 of the Social Security Act, 42 U.S.C. 405(h), 1395u and 1395ff; and 42 C.F.R. 405.504(b) are reproduced at App., *infra*, 36a-40a.

STATEMENT

The court of appeals held in this case that the district court had jurisdiction to entertain a challenge to a regulation affecting the amount of benefits to be paid for physicians' services under Part B of the Medicare Program. This Court previously vacated the judgment of the court of appeals and remanded for further consideration in light of *Heckler* v. *Ringer*, No. 82-1772 (May 14, 1984). See No. 84-120 (Oct. 1, 1984). After initially concluding on remand that *Ringer* required dismissal of this suit, the court of appeals subsequently reinstated its prior holding that the district court had jurisdiction.

A. The Statutory Framework

The Medicare Program is divided into two parts. Part A provides insurance for the reasonable cost of hospital and related post-hospital services. 42 U.S.C. 1395c, 1395d. Part B establishes a voluntary program of supplementary medical insurance covering, in general, 80% of the "reasonable charge" for physicians' and other medical services. 42 U.S.C. 1395k, 1395*l*, 1395x(s).

1. Part A of the Medicare Program authorizes the Secretary to enter into contracts with fiscal intermediaries under which the intermediaries determine whether particular services are covered by Part A and, if so, the amount of benefits that are payable. 42

U.S.C. 1395h. See *Ringer*, slip op. 2-3. If the intermediary determines that a particular service is not covered by Part A, the claimant is entitled to seek reconsideration by the Health Care Financing Administration (HCFA) in the Department of Health and Human Services (HHS). 42 C.F.R. 405.710-405.716. If the intermediary's denial of the claim is affirmed on reconsideration and the amount in controversy is at least $100, the claimant has a statutory right to an evidentiary hearing on the claim before an administrative law judge (ALJ) in HHS. 42 U.S.C. 1395ff(b)(1)(C) and (2). If the ALJ denies the claim and the Appeals Council sustains that decision, the claimant may seek judicial review pursuant to 42 U.S.C. 405(g) if the amount in controversy is $1,000 or more. 42 U.S.C. 1395ff(b)(1)(C) and (2). See *Ringer*, slip op. 3. On judicial review, the court may consider the validity of any regulation that has the effect of limiting or denying Part A benefits to the claimant. See *Ringer*, slip op. 10-11, 13.

The Medicare Act also provides a mechanism for a hospital or other provider of Part A services to obtain review of the amount it will be reimbursed. A provider is paid an aggregate amount for all Part A services it rendered during the relevant time period. See *Heckler* v. *Community Health Services*, No. 83-56 (May 21, 1984), slip op. 2.[1] If the provider is dissatisfied with the intermediary's determination of the total amount of re-

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[1] The method of calculation of payments under Part A has been revised by the enactment of Section 1886 of the Act, 42 U.S.C. 1395ww, which adopts a prospective payment system and directs that providers be reimbursed at a flat rate for particular services. See *Heckler* v. *Redbud Hospital Dist.*, No. A-32 (July 24, 1985), slip op. 1-2 (Rehnquist, Circuit Justice). However, the rights of beneficiaries and providers to administrative and judicial review under Part A continue to be governed by the express provisions in 42 U.S.C. 1395ff and 1395*oo*, which are discussed in the text.

imbursement due and if the amount in controversy is $10,000 or more, the provider may request a hearing before the Provider Reimbursement Review Board (PRRB) in HHS. 42 U.S.C. 1395*oo*(a) and (c). If the decision of the PRRB is adverse to the provider, it then may seek judicial review in federal district court. 42 U.S.C. 1395*oo*(f)(1); *Heckler* v. *Community Health Services*, slip op. 6. The Act expressly allows the provider to obtain judicial review on a question involving the validity of a regulation that has the effect of limiting the amount of reimbursement. 42 U.S.C. 1395*oo*(f)(1).

2. The Part B Medicare Program, at issue here, provides for far more limited review of benefit determinations. The Secretary is authorized to enter into contracts with private insurance carriers under which the carriers determine whether the particular services for which a beneficiary has submitted a claim are covered by Part B and the amount of the "reasonable charge" for such services. 42 U.S.C. 1395u; see *Schweiker* v. *McClure*, 456 U.S. 188, 190 (1982). If the carrier determines that the services for which reimbursement is sought are not covered by Part B or that the payment due is less than the amount claimed, the claimant is entitled by statute to a hearing conducted by the carrier. 42 U.S.C. 1395u(b)(3)(C); see *Schweiker* v. *McClure*, 456 U.S. at 191. However, in contrast to the Part A Program, there is no provision for administrative review by HHS of the carrier's denial of a Part B claim. 42 C.F.R. 405.502(d). Moreover, although 42 U.S.C. 1395ff(b)(1)(C) expressly authorizes a claimant to obtain judicial review of the "amount of benefits" under Part A, there is no parallel provision in 42 U.S.C. 1395ff for a claimant to obtain judicial review of the amount payable on a Part B claim. In *United States* v. *Erika, Inc.*, 456 U.S. 201, 206-211 (1982), this Court held that by this omission, Congress "deliberately intended to fore-

close further review of such claims" (456 U.S. at 208). Accord *Ringer*, slip op. 5 n.4.

The Act likewise does not contain any special procedures, similar to those available to Part A providers under 42 U.S.C. 1395*oo*, for a physician or other supplier of Part B services to obtain administrative review by HHS or judicial review of the amount of benefits payable. If the enrollee assigns his Part B Medicare reimbursement claim to the physician or other person who furnished the services, the assignee has the same right as a beneficiary to an evidentiary hearing by the carrier. 42 C.F.R. 405.801(a); *Erika*, 456 U.S. at 203, 207 n.7. But as the Court held in *Erika*, the assignee has no right to judicial review of the carrier's decision.

B. The Proceedings In This Case

1. The Social Security Act requires the carriers that administer the Part B Program on the Secretary's behalf to make payment for covered services on the basis of the "reasonable charge" for the services. 42 U.S.C. 1395u(b)(3)(B). In determining the reasonable charge, the carrier is to "take[ ] into consideration the customary charges for similar services generally made by the physician * * * as well as the prevailing charges in the locality for similar services." 42 U.S.C. 1395u(b)(3). Applying these principles, the reasonable charge for a physician's services ordinarily is the lowest of (1) the actual charge in the particular instance, (2) the individual physician's customary charge, and (3) the prevailing charge in the locality for similar services (App., *infra*, 2a-3a). See 42 C.F.R. 405.502.

In 1967, the Secretary promulgated the regulation at issue in this case, which recognizes that "[t]he range of prevailing charges in a locality may be different for physicians * * * who engage in a specialty practice or service than for others." 42 C.F.R. 405.504(b). The regulation accordingly permits (but does not require) a carrier, based on "[e]xisting differentials in the level of

charges between different kinds of practice or service," to develop more than one range of prevailing charges.

Consistent with this regulation, Blue Cross/Blue Shield of Michigan (BC/BSM), the carrier responsible for administering the Part B Program in Michigan, conducted a statistical analysis of physicians' charges in that State in 1968. Based on its analysis, BC/BSM identified three categories of physicians for reimbursement purposes: (1) hospital internists and other hospital specialists, (2) other specialists, and (3) general practitioners and other nonspecialists. The prevailing charges for specialists in Michigan were higher than those for nonspecialists, and a Part B beneficiary therefore could receive a greater reimbursement if he was treated by a specialist. App., *infra*, 4a. Following creation of the family practice specialty, BC/BSM in 1973 classified Board-certified family practitioners in the specialist category, but family physicians who were merely eligible for Board certification and family physicians who were neither Board-eligible nor Board-certified were grouped with the nonspecialists. *Ibid.*[2]

2. Respondents filed this action on October 8, 1976 in the United States District Court for the Eastern District of Michigan to challenge BC/BSM's classification of family practitioners (C.A. App. 1, 11-29). The initial plaintiffs were the Michigan Academy of Family Physicians, one Board-certified family practitioner, and two Board-eligible family practitioners (C.A. App. 19). Later, a Part B enrollee who was the patient of a family practitioner who was neither Board-certified nor Board-eligible was joined as a plaintiff (App., *infra*, 31a-32a).

The district court held that the establishment of separate charge screens that distinguish non-Board certi-

[2] The government acknowledged in proceedings in district court in this case that Board-eligible family physicians should have been included in the specialist category (App., *infra*, 27a).

fied family physicians from other physicians violated the Medicare Act and that to the extent 42 C.F.R. 405.504(b) authorized the screens established by BC/BSM, it was invalid. The court relied on 42 U.S.C. 1395u(b)(3), which requires the carrier to "take[ ] into consideration" the prevailing charges for "similar services" and to establish a ceiling based on the prevailing charge level that would cover 75% of the customary charges for "similar services" in the locality. In the court's view, these provisions required that similar services be reimbursed at an identical rate, even when performed by physicians with different degrees of specialization. App., *infra*, 29a-30a. The court also was of the view that the maintenance of three charge screens impermissibly "tends to influence the patient's choice of a physician" (*id.* at 30a-31a). Finally, the court concluded that BC/BSM did not have an adequate factual or statistical basis for distinguishing among groups of physicians (*id.* at 28a). As a remedy, the district court ordered the Secretary and BC/BSM to establish two categories for determining prevailing charges: the first for all physicians, and the second for chiropractors, podiatrists, and dentists (*id.* at 32a-33a).

3. a. In an opinion dated February 23, 1984, the court of appeals affirmed the district court's ruling but modified the remedy (App., *infra*, 1a-15a). As a threshold matter, the court of appeals rejected the Secretary's contention that the district court's exercise of jurisdiction under 28 U.S.C. 1331 was barred by 42 U.S.C. 1395ff and 405(h) (App., *infra*, 6a-11a). The court recognized that this Court's decision in *Erika* foreclosed judicial review of the amount of reimbursement for services under Part B of the Medicare Program (App., *infra*, 6a-8a). But the court observed that in the wake of *Erika*, several lower courts had "strenuously endeavored to find jurisdiction" over challenges to certain aspects of the Medicare Program (App.,

infra, 8a), and it elected to do the same. Thus, although the court of appeals acknowledged that "the eventual result of this suit may cause an increase in amounts of reimbursement" for services rendered by family physicians (*ibid.*), it nevertheless held that this suit was not barred by the preclusion of review in 42 U.S.C. 1395ff because respondents were challenging the "mechanism" for computing the reasonable charge for particular services, not the reasonable charge itself (App., *infra*, 8a-9a).

The court of appeals further concluded that the district court's exercise of federal question jurisdiction under 28 U.S.C. 1331 was not barred by 42 U.S.C. 405(h), as incorporated into the Medicare Program by 42 U.S.C. 1395ii (App., *infra*, 9a-11a). The court acknowledged that in *Weinberger* v. *Salfi*, 422 U.S. 749 (1975), and subsequent decisions, this Court had held that the third sentence of Section 405(h) prohibited a court from exercising federal question jurisdiction to entertain any claim arising under the Social Security Act. But it noted that in *Salfi* and the other decisions, this Court had referred to the availability of an alternative method for obtaining judicial review pursuant to 42 U.S.C. 405(g). Because there is no provision for review of Part B Medicare claims under 42 U.S.C. 405(g), the court of appeals reasoned that 42 U.S.C. 405(h) should not be construed to preclude federal question jurisdiction over a suit arising under Part B. App., *infra*, 10a-11a.

b. On the merits, the court of appeals held that BC/BSM's calculation of the amount of reimbursement for family physicians' services by reference to the separate prevailing charge screens was invalid (App., *infra*, 11a-14a). In the court's view, the "touchstone of [42 U.S.C. 1395u(b)(3)] is that similar services, once determined, are to be compensated equally, regardless of who performs them" (App., *infra*, 12a). The court further explained that its decision to invalidate the regula-

tion was "bolstered" by its view that the reimbursement approach BC/BSM followed might create an added incentive for physicians to become specialized and for patients to seek specialized care (*id.* at 13a-14a). The latter incentive, the court believed, was sufficient to support a finding that "the regulation as applied violates 42 U.S.C. § 1395a, prohibiting infringement of a patient's free choice of a physician" (App., *infra*, 14a). However, the court of appeals concluded that the district court's remedy went "too far," and it instead remanded the case to the Secretary "with instructions to consider similar services in an equal manner regardless of who performs that service" (*id.* at 14a-15a).

4. The Secretary and BC/BSM then filed a petition for a writ of certiorari, arguing that the court of appeals' jurisdictional ruling was inconsistent with this Court's decisions in *Ringer* and *Erika*. The Court granted the petition, vacated the judgment of the court of appeals, and remanded the case to the court of appeals for further consideration in light of *Ringer*. See No. 84-120 (Oct. 1, 1984).

5. On remand, the court of appeals at first remanded the case to the district court with instructions to dismiss for lack for jurisdiction, explaining that "the principles stated by the Supreme Court in *Heckler* v. *Ringer* require us to find that the federal courts lack jurisdiction over the present case" (App., *infra*, 16a). However, on respondents' petition for rehearing, the panel reversed itself once more and held that *Ringer* and *Erika* did not preclude the exercise of jurisdiction in this case (App., *infra*, 17a-22a).

The court of appeals acknowledged in its opinion on rehearing that this Court, in footnote 4 of its opinion in *Ringer*, held that judicial review was barred insofar as that case arose under Part B of the Medicare Program (App., *infra*, 21a). But although this Court expressly

relied for this proposition on its prior decision in *Erika* (see *Ringer*, slip op. 5 n.4), which in turn relied on 42 U.S.C. 1395ff (see 456 U.S. at 206-211), the court of appeals stated that "[i]n reaching its decision in *Heckler* v. *Ringer*[,] the Supreme Court did not rely on § 1395ff" (App., *infra*, 18a n.2). The court of appeals therefore did not discuss 42 U.S.C. 1395ff.

With regard to the additional preclusion of review in 42 U.S.C. 405(h), the court of appeals acknowledged that this Court held in *Ringer* that the challenge to the regulation there at issue fell within the coverage of Section 405(h) (App., *infra*, 19a-20a) and that the application of the jurisdictional bar in Section 405(h) does not depend on whether judicial review of the particular claim is otherwise available under the Social Security Act itself (App., *infra*, 21a-22a). But without explaining why *Ringer* was not therefore dispositive, the court of appeals held that the district court did have jurisdiction in this case under 28 U.S.C. 1331, relying on nothing more than a "presumption" favoring judicial review and its notion that "for every right there must be a remedy" (App., *infra*, 22a). The court of appeals further held that *Ringer* does not in any event foreclose judicial review by "a party other than a claimant for benefits" (App., *infra*, 21a, 22a)—presumably meaning the physicians who challenged the regulation and charge screens but did not submit an actual claim for reimbursement. For the foregoing reasons, the court reinstated its February 23, 1984 opinion sustaining the district court's exercise of jurisdiction under 28 U.S.C. 1331 (App., *infra*, 22a).[3]

REASONS FOR GRANTING THE PETITION

The decision of the court of appeals permitting judicial review of matters pertaining to the amount of bene-

[3] The Secretary's petition for rehearing en banc was denied in an order dated May 30, 1985 (App., *infra*, 35a).

fits payable under the Part B Medicare Program is flatly inconsistent with this Court's decisions in *United States* v. *Erika, Inc.*, 456 U.S. 201 (1982), and *Heckler* v. *Ringer*, No. 82-1772 (May 14, 1984). Those cases, like this one, involved challenges to a regulation or instruction issued by the Secretary that had the effect of limiting the amount of benefits the carrier could award on a particular claim, and the Court's holdings in *Erika* and *Ringer* therefore squarely control this case. The court of appeals' failure to follow *Ringer*, after it was given an opportunity by this Court to do so, is inexplicable. "[U]nless we wish anarchy to prevail within the federal judicial system, a precedent of this Court must be followed by the lower federal courts no matter how misguided the judges of those courts may think it to be." *Hutto* v. *Davis*, 454 U.S. 370, 375 (1982).

In direct conflict with the decision below, the Fourth Circuit recently held, also following a remand by this Court, that *Ringer* required the dismissal for lack of jurisdiction of a challenge to a regulation that had the effect of limiting the amount of benefits payable for particular services under Part B. *Starnes* v. *Schweiker*, 748 F.2d 217 (4th Cir. 1984), cert. denied, No. 84-1309 (Apr. 15, 1985). That conflict warrants resolution by this Court, especially since the decision below threatens to foster once again the widespread litigation on questions pertaining to the amount of reimbursement under Part B that prevailed prior to *Erika*. Because this Court already has resolved the precise issue presented in this case and because the court of appeals offered no substantial basis for distinguishing this case from *Ringer*, there is no need for the Court to grant plenary review here. We therefore suggest that summary reversal of the judgment below is appropriate.

1. Respondents invoked the jurisdiction of the district court under 28 U.S.C. 1331 to challenge the prevailing charge screens used to calculate the amount of

Part B Medicare benefits paid for services furnished by family physicians. Judicial review of such matters is barred by two separate provisions of the Social Security Act. The first is 42 U.S.C. 1395ff, which exclusively governs the availability of judicial review for participants in the Medicare Program, but does not provide for such review of the amount of benefits under Part B. The second is 42 U.S.C. 405(h), as incorporated into the Medicare Program by 42 U.S.C. 1395ii, which precludes the bringing of an action under 28 U.S.C. 1331 to recover on any claim "arising under" the Social Security Act.

a. In 42 U.S.C. 1395ff(a), Congress provided that "the determination of the amount of benefits under part A [of the Medicare Program] shall be made by the Secretary in accordance with regulations prescribed by [her]." The Secretary is authorized to enter into contracts with fiscal intermediaries to make these initial determinations on her behalf. See 42 U.S.C. 1395h. Under 42 U.S.C. 1395ff(b), an individual who is dissatisfied with the intermediary's determination as to "the amount of benefits under part A" is entitled to a hearing before an ALJ in HHS if the amount in controversy is $100 or more and to judicial review, as provided in 42 U.S.C. 405(g), if the amount in controversy is $1,000 or more.

Under Part B, determinations and evidentiary hearings with respect to the amount of benefits on a particular claim are conducted entirely by private insurance carriers; there is no provision in 42 U.S.C. 1395ff(b) for review by HHS. Moreover, as this Court recognized in *Erika* (456 U.S. at 208), 42 U.S.C. 1395ff(b) likewise conspicuously fails to authorize *judicial* review of the "amount of benefits" under Part B, even though it expressly authorizes such review under Part A. In light of the Act's "precisely drawn provisions," the Court in *Erika* found this omission persuasive evidence that

Congress had "deliberately * * * foreclose[d]" judicial review of benefit amount determinations under Part B. 456 U.S. at 208. The Court in *Erika* further found that this preclusion of review was "unambiguously support[ed]" by the legislative history of Section 1395ff. 456 U.S. at 208-211.[4] Respondents' challenge in this case pertains directly to the carrier's calculation of the "amount of benefits" to be paid under Part B for services furnished by family physicians. It therefore is foreclosed by the very text and legislative history of 42 U.S.C. 1395ff that compelled the Court's unanimous holding in *Erika*.

Respondents cannot avoid that conclusion by styling their suit as a challenge only to the regulation issued by the Secretary, not the actual amount of benefits awarded by the carrier. The regulation at issue authorizes (but does not require) a carrier to establish different prevailing charge levels for services performed by physicians and others who have different degrees of specialization. Respondents challenge that regulation precisely because the carrier in Michigan has chosen to establish a different screen for certain family physicians that in turn operates as a ceiling on the amount of benefits payable under Part B for services rendered by those physicians. Indeed, in order even to have standing to bring this suit, respondents must rely on the effect the regulation has on the amount of benefits pay-

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[4] The Court quoted the Senate Report on the original Medicare Act, which stated that the Act did not provide for judicial review of "a determination concerning the amount of benefits under part B" and that the provision for review by carriers under Part B was intended to be the "exclusive" remedy. See 456 U.S. at 208, 209 n.11, quoting S. Rep. 404, 89th Cong., 1st Sess. 54-55 (1965). The Court also quoted the Conference Report on the 1972 amendments to 42 U.S.C. 1395ff, which explained that "there is no authorization * * * for judicial review on matters solely involving amounts of benefits under Part B" (456 U.S. at 210, quoting H.R. Conf. Rep. 92-1605, 92d Cong., 2d Sess. 51 (1972)).

able (compare *Ringer*, slip op. 11-12), and the court of appeals acknowledged that "the eventual result of this suit may cause an increase in amounts of reimbursement" (App., *infra*, 8a). Thus, the preclusion of review in 42 U.S.C. 1395ff applies fully to challenges to regulations that underlie the carrier's decision concerning the amount of benefits.[5]

Respondents' contention at bottom is that separate charge screens are not authorized by the Medicare Act, which the regulation at issue merely implements. Their legal argument therefore would be exactly the same if the Secretary had never promulgated the regulation and the carrier in Michigan had adopted the separate screens based solely on its own interpretation of the Medicare Act.[6] As *Erika* itself makes clear, such a statutory challenge to the carrier's actions is foreclosed by 42 U.S.C. 1395ff. See 456 U.S. at 204-205. In any event, in *Erika* itself, the plaintiff's claim to increased benefits was based in part on a challenge to instructions issued by the Secretary, which bound the carriers in the same manner as formal regulations (see *Ringer*, slip

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[5] This conclusion also is evident from the structure of 42 U.S.C. 1395ff. In 42 U.S.C. 1395ff(b), Congress has authorized judicial review of the "amount of benefits under part A," which, under 42 U.S.C. 1395ff(a), is determined in accordance with regulations issued by the Secretary. As we have said (see page 3, *supra*), judicial review under Part A may include a challenge to regulations that establish benefit amounts or guide fiscal intermediaries in computing those amounts. The corresponding *foreclosure* of judicial review under Part B accordingly must extend to challenges to instructions or regulations issued by the Secretary that have the effect of limiting the amount of benefits determined by a carrier.

[6] As this Court observed in *Ringer* (slip op. 13), the determination by the Secretary whether to promulgate a generally applicable rule to resolve a particular issue, or instead to permit individual adjudication, is a matter committed to the Secretary's discretion. The availability of judicial review under Part B should not turn on whether the Secretary has chosen to promulgate such a regulation or instead left the issue to the carrier to resolve.

op. 3-4; 42 C.F.R. 405.860) and which limited the amount of benefits that could be awarded by the carriers. See *Erika, Inc.* v. *United States*, 634 F.2d 580, 590-591 (Ct. Cl. 1980). This Court nevertheless held that judicial review was foreclosed.[7]

If there could be any doubt remaining on this point after *Erika*, it was dispelled by the decision in *Ringer*. That case involved a challenge to a regulation issued by the Secretary that prohibited the payment of *any* amount of benefits under Medicare for a particular medical service. Slip op. 2-5. Yet the Court held, without dissent, that insofar as the regulation applied to the Part B Program, judicial review of the regulation was barred by this Court's decision in *Erika*. *Ringer*, slip op. 5 n.4. The Court so held even though the plaintiffs in *Ringer*, like respondents herein, did not actually request the Court to award benefits, but instead sought only an invalidation of the regulation that would bind the carrier in its subsequent adjudication of individual claims. Slip op. 9-10, 12. Because the Court in *Ringer* explicitly relied on *Erika*, which in turn relied on the foreclosure of review in 42 U.S.C. 1395ff, the court of appeals in this case was simply mistaken when it stated that "[i]n reaching its decision in [*Ringer*], the Supreme

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[7] It is worth noting that in *Erika*, the American Academy of Family Physicians, represented by counsel who also represents respondents in this case, filed a brief as amicus curiae. That brief argued extensively that 42 U.S.C. 1395ff should not be read to foreclose regulatory, statutory or constitutional challenges to a carrier's actions, even if review of essentially arithmetic computations of benefit amounts is foreclosed (Amicus Br. at 15-18, 21 n.13, 23, 25-27). The brief also relied upon the district court's decision in the instant case as an example of the sort of statutory challenge to a carrier's actions that, like the claim in *Erika* itself, should not be foreclosed by 42 U.S.C. 1395ff (Amicus Br. at 28). Respondents therefore are attempting in this case to reargue the position that was advanced on behalf of family physicians but was rejected by this Court in *Erika*.

Court did not rely on § 1395ff" (App., *infra*, 18a n.2). And this error might explain the court of appeals' otherwise inexplicable assertion that its jurisdictional holding was not inconsistent with *Ringer* (App., *infra*, 22a).

b. The correctness of the result indicated by 42 U.S.C. 1395ff standing alone—that judicial review of a regulation affecting the calculation of the amount of benefits under Part B is foreclosed because it is not expressly authorized by the Social Security Act—is confirmed by 42 U.S.C. 405(h), which is made applicable to the Medicare Program by 42 U.S.C. 1395ii. The second sentence of Section 405(h) provides that "[n]o findings of fact or decision of the Secretary shall be reviewed by any person, *tribunal*, or governmental agency *except as herein provided*" (emphasis added). This sentence embodies a general rule under the Social Security Act that judicial review is unavailable except where and in the manner such review is expressly authorized by that Act.[8] Because Congress has not affirmatively provided for judicial review under Part B in the Social Security Act itself, the second sentence of Section 405(h) precludes such review.

The third sentence of Section 405(h) further provides that "[n]o action against the * * * Secretary * * * shall be brought under section [ ] 1331 * * * of title 28 to recover on any claim arising under this subchapter." The court of appeals' holding that the district court had jurisdiction in this case under 28 U.S.C. 1331 directly contravenes this jurisdictional bar as well. This conclusion, too, is compelled by *Ringer*. There, the Court held that Section 405(h) barred the bringing of an action under 28 U.S.C. 1331 to challenge instructions issued by the Secretary to fiscal intermediaries and a formal rul-

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[8] Because carriers make determinations on claims for benefits under Part B on behalf of the Secretary (see *Schweiker* v. *McClure*, 456 U.S. at 190), this preclusion of review applies equally to findings and decisions by the carriers under Part B.

ing (equivalent to a regulation) issued by the Secretary that had the effect of barring the payment of benefits under Medicare for a particular type of surgery. *Ringer*, slip op. 10-12, 16-23. The Court explained that the plaintiffs' assertedly "procedural" challenge to those directives was inextricably intertwined with their substantive claims to benefits and that the challenge therefore could be raised only in an action for judicial review under the Social Security Act itself—pursuant to 42 U.S.C. 405(g), after full exhaustion of administrative remedies. *Ringer*, slip op. 9-12.

The court of appeals' holding in its original opinion in the instant case that Section 405(h) does not bar review because respondents purport to challenge only the "procedure" utilized by the carrier to calculate benefits, not the amount of benefits paid on a particular claim (App., *infra*, 10a), is squarely inconsistent with *Ringer*. Following this Court's remand, the court of appeals recited this controlling aspect of *Ringer* (App., *infra*, 19a-20a), but it nevertheless reinstated its prior opinion finding jurisdiction under 28 U.S.C. 1331 (App., *infra*, 22a), apparently relying once again on the asserted distinction, rejected in *Ringer*, between a challenge to a regulation affecting the amount of benefits and a challenge to a decision on a particular claim for benefits (App., *infra*, 18a-19a, 20a).

The court of appeals also sought in its original opinion to distinguish this Court's decisions construing Section 405(h) on the ground that in *Salfi* and its progeny, judicial review was in any event available under 42 U.S.C. 405(g), whereas if Section 405(h) were read to bar federal question jurisdiction under Part B, judicial review would be entirely foreclosed because 42 U.S.C. 405(g) is not available as an alternative avenue for judicial review under Part B. See App., *infra*, 10a. Thereafter, this Court in *Ringer* explicitly rejected the proposition that the meaning of Section 405(h) somehow shifts de-

pending on whether review is available under Section 405(g). *Ringer*, slip op. 19. Yet on remand after *Ringer*, the court of appeals expressly credited this very argument (App., *infra*, 19a, 20a, 21a).

c. The court of appeals also held on remand that *Ringer* does not bar challenges by "a party other than a claimant for benefits" (App., *infra*, 22a), by which the court apparently meant the physicians who challenged the regulation and charge screens but did not request the court to award benefits. This attempt to distinguish *Ringer* is frivolous. In *Ringer*, one plaintiff had not yet had the BCBR surgery and thus was not in a position to submit a request for benefits to the intermediary. The Court nevertheless held that 42 U.S.C. 405(h) foreclosed the bringing of an action under 28 U.S.C. 1331 to challenge the Secretary's ruling that barred payment for the surgery. *Ringer*, slip op. 16-23. The physicians in this case are in exactly the same position. They could have standing to challenge the regulation authorizing separate charge screens only because they have submitted or will submit assigned claims for benefits that would be affected by those charge screens. Under *Ringer*, the fact that they have not yet done so (if indeed that is the case) does not remove them from the jurisdictional bar in Section 405(h).

It would, moreover, be anomalous indeed for Congress to permit *physicians* to obtain judicial review but to deny such review to *beneficiaries*, who pay premiums to be insured under the Part B Program and therefore are most directly affected by regulations limiting the amount of benefits that may be paid. The Act itself demonstrates that Congress did no such thing. A carrier administering the Part B Program on behalf of the Secretary may make payment to a physician only if the beneficiary has assigned his claim for benefits to the physician. 42 U.S.C. 1395u(b)(3)(B)(ii). Although the Act grants a right of administrative review only to an

"individual enrolled under [Part B]," 42 U.S.C. 1395u(b)(3)(C), the Secretary by regulation has provided that a physician who accepts an assignment stands in the shoes of the beneficiary and has the same right to administrative review by the carrier. 42 C.F.R. 405.801(a); *Erika*, 456 U.S. at 207 n.7. But the assignee physician also is subject to the same preclusion of *judicial* review that applies to the beneficiary. The Court so held in *Erika*. There it was the supplier of Part B services, not the beneficiaries themselves, who sought judicial review.

The foreclosure of review is confirmed by a comparison with the Part A Program. Under Part A, Congress enacted a separate mechanism by which a hospital or other provider may obtain judicial review of the amount of reimbursement it will receive for services it renders to Medicare beneficiaries. 42 U.S.C. 1395*oo*(f)(1); see pages 3-4, *supra*. "In the context of the statute's precisely drawn provisions," the fact that Congress expressly authorized judicial review for providers under Part A, but not for their counterparts under Part B (in this case, physicians), furnishes persuasive evidence that Congress "deliberately intended to foreclose" review in the latter situation. *Erika*, 456 U.S. at 208. See also *Block* v. *Community Nutrition Institute*, No. 83-458 (June 4, 1984), slip op. 6.

d. In the end, the court of appeals was forced to rely on nothing more than a "presumption" in favor of judicial review, believing that "for every right there must be a remedy" (App., *infra*, 22a). But this Court made clear in *Block* v. *Community Nutrition Institute*, *supra*, that "[t]he presumption favoring judicial review of administrative action is just that—a presumption" (slip op. 8)—and that it may be overcome by a consideration of the language, structure, purpose and legislative history of the statute and the nature of the administrative action involved (*id.* at 5, 8-11). When the court of

appeals first ruled, this Court already had held in *Erika* that a congressional intent to preclude judicial review under Part B was "persuasive[ly] evidence[d]" by the text of 42 U.S.C. 1395ff (456 U.S. at 208) and "unambiguously support[ed]" by its legislative history (*id.* at 211). Subsequently, the Court, without dissent, adhered to that view in *Ringer* (slip op. 5 n.4). Needless to say, these holdings should have been sufficient for the court of appeals, on remand after *Ringer*, to overcome the presumption in favor of judicial review.

2. a. The decision of the court of appeals in this case directly conflicts with the Fourth Circuit's recent decision in *Starnes* v. *Schweiker*, 748 F.2d 217 (1984), cert. denied, No. 84-1309 (Apr. 15, 1985). There, the Fourth Circuit, like the Sixth Circuit in the instant case, initially held that 42 U.S.C. 1395ff and 42 U.S.C. 405(h) did not bar federal question jurisdiction over a challenge to directives issued by the Secretary that limited payments for certain Part B services. *Starnes* v. *Schweiker*, 715 F.2d 134 (1983). This Court subsequently vacated the Fourth Circuit's judgment and remanded for further consideration in light of the intervening decision in *Ringer*. *Heckler* v. *Starnes*, No. 83-1149 (June 4, 1984). Faithful to that mandate, the Fourth Circuit on remand held that the suit must be dismissed for lack of jurisdiction. It explained (748 F.2d at 218):

> *Ringer* establishes that we misread *Erika*. *Ringer* decides that Starnes' contention that there were procedural irregularities in the promulgation of the caps [is] so inextricably intertwined with a claim for benefits that any judicial review is barred by 42 U.S.C. § 1395ff.

Similarly here, respondents' challenge to the regulation and the separate charge screens it authorizes is intertwined with the claims for benefits that are affected by those screens, and judicial review therefore is barred by 42 U.S.C. 1395ff. The court of appeals' deci-

sion in this case thus conflicts with *Starnes*. That conflict warrants resolution by this Court.

b. Other courts of appeals, following *Ringer*, have further recognized that "whether a claimant challenges the procedures used by the Secretary to reject a claim or challenges the substantive basis for that rejection, [42 U.S.C.] 405(h) makes [28 U.S.C.] 1331 jurisdiction unavailable." *Ganem* v. *Heckler*, 746 F.2d 844, 848 (D.C. Cir. 1984). See also *American Federation of Home Health Agencies, Inc.* v. *Heckler*, 754 F.2d 896, 897-898 (11th Cir. 1984); *Smith* v. *North Louisiana Medical Review Ass'n*, 735 F.2d 168, 171-172 (5th Cir. 1984). The decision below finding jurisdiction under 28 U.S.C. 1331 over respondents' challenge to the manner in which the carrier calculates the reasonable charge conflicts with these decisions as well.

c. We had assumed that, whatever other jurisdictional issues under the Social Security Act remain unresolved,[9] it at least was firmly established that judicial review under Part B of the Medicare Act is entirely foreclosed (at least in the absence of a constitutional challenge to the Medicare Act itself, cf. *Schweiker* v. *McClure*, *supra*). The Sixth Circuit's ruling in this case does away with that assumption and threatens to reintroduce the regime of uncertainty and widespread litigation on Part B issues that prevailed prior to

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[9] We have recently sought review of jurisdictional rulings in three cases arising under Title II or Title XVI of the Social Security Act, 42 U.S.C. 401 *et seq.*, 1381 *et seq.* See *Heckler* v. *Owens*, appeal pending, No. 84-1905 (docketed June 5, 1985); *Heckler* v. *City of New York*, petition for cert. pending, No. 84-1923 (filed June 7, 1985); *Heckler* v. *Polaski*, petition for cert. pending, No. 85-55 (filed July 11, 1985).

Erika.[10] This Court should not permit such a disregard of its clear pronouncements.[11]

CONCLUSION

The petition for a writ of certiorari should be granted, and the judgment of the court of appeals should be summarily reversed.

Respectfully submitted.

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AUGUST 1985

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[10] Several district courts likewise have failed to follow *Ringer* in Part B Medicare cases, thereby underscoring the potential for such litigation. See, *e.g.*, *National Association of Patients on Hemodialysis & Transplantation, Inc.* v. *Heckler*, 588 F. Supp. 1108, 1115-1118 (D.D.C. 1984); *Bio-Medical Applications of Providence, Inc.* v. *Heckler*, 593 F. Supp. 1233, 1235-1236 (D.D.C. 1984), appeal pending, No. 84-5802 (D.C. Cir.); *Linoz* v. *Heckler*, 598 F. Supp. 486 (D. Hawaii 1984), appeal pending, No. 84-2446 (9th Cir.).

[11] Because the district court clearly was without jurisdiction in this case, we have not sought review of the court of appeals' decision on the merits. However, for the reasons stated in our previous petition for a writ of certiorari in this case (84-120 Pet. 12 n.5), it is our view that the court of appeals' invalidation of the relevant regulation, which was promulgated only one year after the Medicare Program went into effect, was plainly incorrect. We shall not repeat that discussion here.

APPENDIX A

UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

No. 81-1202

MICHIGAN ACADEMY OF FAMILY PHYSICIANS, ET AL., PLAINTIFFS-APPELLEES,

v.

BLUE CROSS AND BLUE SHIELD OF MICHIGAN AND RICHARD S. SCHWEIKER, SECRETARY OF HEALTH AND HUMAN SERVICES, DEFENDANTS-APPELLANTS

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF MICHIGAN

[Filed Feb. 23, 1984]

Before: JONES, Circuit Judge; PECK and BROWN, Senior Circuit Judges.

PECK, Senior Circuit Judge. The principal question raised in this appeal is the validity of the method adopted by the Department of Health and Human Services (HHS) by which certain eligible individuals receive reimbursement for services performed by physicians and other individuals pursuant to the federal Health Insurance for the Aged and Disabled Act (Medicare), 42 U.S.C. § 1395 *et seq.* The Michigan Academy of Family Physicians (Michigan Academy) filed suit against Blue Cross and Blue Shield of Michigan (BC/BSM) and Richard S. Schweiker, Secretary of HHS (Secretary). The complaint alleges that the classification of certain family physicians separately from other physicians with

similar qualifications, and together with non-allopathic doctors (such as chiropractors and podiatrists), contraverted the statutory mandate of Congress as expressed in the Medicare Act. A violation of due process and equal protection rights under the fifth amendment of the United States Constitution is also claimed. The district court, after finding jurisdiction, held that the classification violated the Medicare Act, §§ 1395u(b)(3) & 1395a, and ordered the Secretary to include all family physicians with other medical doctors. BC/BSM and the Secretary appeal.

BACKGROUND

The Medicare Act consists of two programs. Part A provides insurance for hospitalization and post-hospital services. 42 U.S.C. § 1395c-1395i-2. Part B, at issue in this case, provides insurance for supplemental medical care. 42 U.S.C. § 1395j-1395w. Under part B eligible individuals may voluntarily enroll in the health insurance program by paying a monthly premium. Members enrolled in the program may request reimbursement of eighty per cent of the reasonable charges, as defined by the insurance carrier, of the services rendered, or assign the right of reimbursement to their physician, 42 U.S.C. § 1395u(b)(3)(B)(ii).

As directed by statute, the Secretary is required to contract with an insurance intermediary to administer the Medicare part B program. 42 U.S.C. § 1395u. According to statute, the carrier is responsible for determining reasonable fees for covered services in order to calculate the applicable reimbursement amount. *Id.* The Act further provides that a carrier, in calculating these reimbursements, is to consider "the customary charges for similar services generally made by the physician or other person furnishing such services, as well as the prevailing charges in the locality for similar services." 42 U.S.C. § 1395u(b)(3). Price ceilings are placed on the calculation of the reasonable fee so that such fee is not

reasonable if it exceeds either the prevailing or customary fees as calculated under the Medicare Act.[1]

In August, 1967, the Secretary validly promulgated 42 C.F.R. § 405.504. 32 Fed. Reg. 12600 (1967). After first restating the definition of prevailing charges, the regulation in part B permits carriers to establish separate prevailing charges for "specialists" and "non-specialists" and specifically provides that carriers can develop more than one set of prevailing charges based on fee patterns in a local area. As a practical result of this regulation, carriers developed separate and distinct prevailing charges for different types of physicians. Under the regulation, patients receiving one type of service from a specialist are entitled to incur a higher reasonable charge, and therefore to receive a larger reimbursement than if they received the identical service from a non-specialist.

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[1] 42 U.S.C. § 1395u(b)(3) provided a complex methodology for calculating the specific amounts of each category. The section provides in pertinent part:

> In determining the reasonable charge for services for purposes of this paragraph, there shall be taken into consideration the customary charges for similar services generally made by the physician or other person furnishing such services, as well as the prevailing charges in the locality for similar services. No charge may be determined to be reasonable in the case of bills submitted or requests for payment made under this part after December 31, 1970, if it exceeds the higher of (i) the prevailing charge recognized by the carrier and found acceptable by the Secretary for similar services in the same locality in administering this part on December 31, 1970, or (ii) the prevailing charge level that, on the basis of statistical data and methodology acceptable to the Secretary, would cover 75 percent of the customary charges made for similar services in the same locality during the last preceding calendar year elapsing prior to the start of the fiscal year in which the bill is submitted or the request for payment is made....

FACTS

Beginning in 1966 the Secretary contracted with BC/BSM to administer the Medicare part B program in the state of Michigan. BC/BSM, in initially determining charges, lumped physicians into three groups for the purpose of calculating prevailing charges in each geographic locality in Michigan. One group consisted exclusively of hospital internists and other hospital specialists. A second group consisted of certified specialists. The final group consisted of general practitioners and other non-specialists. Thereafter, with the passage of 42 U.S.C. § 1395x(r), including other non-allopathic doctors such as chiropractors, dentists, and podiatrists in the Medicare Program, BC/BSM restructured its prevailing charge screens, devising the present system. Group 1 consisted of hospital personnel and other internists. Group 2 consisted of specialists and board certified specialists or board eligible specialists. Group 3 included general practitioners, board eligible family physicians, and other non-physicians added in the 1972 amendment to the Medicare statute.

Under the Medicare system existing in Michigan, and in several other states, a physician determines what services he will perform for a patient. If covered by the Medicare Act, he assigns the service a procedural code or number from those denoted by the Secretary. BC/BSM, after determining what type of physician performed the service, will thereupon reimburse the patient, or his assignee, based in part on the prevailing charge screen within which the physician is classified. In practice, enrollees receiving services from a specialist would receive a larger reimbursement amount than if they received similar services from a general practitioner performing the same service.

The Michigan Academy, a nonprofit Michigan corporation representing family physicians throughout the state, filed suit against BC/BSM and the Secretary,

arguing that the Michigan reimbursement procedure violated the Medicare statute and was unconstitutional. It alleged that the use of prevailing charge screens ignored the Medicare Act's mandate to reimburse equal amounts for similar services performed. Further, Michigan Academy alleged, the use of prevailing charge screens had an impermissible impact on an enrollee's choice of a physician and unduly infringed the free practice of medicine. Alternatively, Michigan Academy argued that the procedure denied its members equal protection and due process under the fifth amendment of the United States Constitution since 42 C.F.R. § 405.504 irrationally classified them together with nonallopathic doctors rather than with other specialists with whom they shared similar qualifications and talents.

At trial no witness for Michigan Academy or BS/BSM could explain why family physicians were separately categorized from all other medical specialists. BC/BSM, in addition, indicated that its classifications were not based on any particular statistical data but that they had apparently evolved over the years.

At the close of all the evidence, the district judge held that § 405.504 violated the Medicare Act. He found that the Medicare Act mandated equal reimbursements for similar services performed despite the type of physician performing them, and that the prevailing charge screens improperly infringed on a patient's free choice in selecting a physician. At the same time, while indicating on several occasions that he felt the regulation was irrational and without support in the trial record, the district judge specifically refused to rule that the regulation is unconstitutional. Holding only that the regulation violated the Medicare Act, the district judge ordered the Secretary to reclassify all physicians together, including family physicians, in one single prevailing charge screen.

On appeal, BC/BSM and the Secretary argue initially that the district court lacked jurisdiction to render its decision. In the alternative, they contend that § 405.504 is a permissible interpretation by HHS of the language of the Medicare Act and that the classification of certain family physicians is constitutional. Even if this court disapproves § 405.504 and finds it unconstitutional, BC/BSM and the Secretary argue, the district judge's remedy of restructuring the prevailing price screens was improper. The court, they contend, should remand the case to the Secretary to allow for a proper restructuring of the reimbursement procedure.

JURISDICTION

We initially turn to the thorny question of whether the district court had jurisdiction to render a decision in this case. In its brief BC/BSM contends that § 205(h) of the Social Security Act, 42 U.S.C. § 405(h), as interpreted by the courts, precludes jurisdiction in this case. BC/BSM first characterizes this cause as a dispute over the amount of reimbursements owed a recipient under the Medicare part B program, an area in which Congress specifically foreclosed judicial review. Since § 1395ff provides a complex administrative methodology for resolving such appeals, BC/BSM urges, no judicial review of such matters is available. In the alternative, they contend that even though § 1395ff is silent on the question of judicial review of decisions by the Secretary made in the course of implementing the Medicare part B program federal question jurisdiction under 28 U.S.C. § 1331 is specifically precluded by § 405(h).

It is well-settled that there is no judicial review of disputes simply concerning the amount of reimbursement or an individual's eligibility to receive Medicare part B benefits. The Supreme Court in *United States* v. *Erika, Inc.*, 456 U.S. 201 (1982), interpreting 42

U.S.C. § 1395ff,[2] held that Congress clearly and convincingly intended that no judicial review of such questions was permissible. The Court found that the legislative history of § 1395ff, as well as the presence of an elaborate administrative review mechanism, clearly showed Congress's intent to bar such disputes from judicial consideration. Id. at 208-09. Among the numerous concerns Congress had mentioned and the Court found important was the need to stem the potential avalanche of litigation concerning the amount of reimbursement. *Id.* In finding that no federal question jurisdiction existed for adjudicating questions involving the amount of reimbursements under Medicare part B, the Supreme Court left open the question of whether all claims in-

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[2] Section 1395ff provides in pertinent part:

> (a) The determination of whether an individual is entitled to benefits under part A or part B, and the determination of the amount of benefits under part A, shall be made by the Secretary in accordance with regulations prescribed by him.
>
> (b)(1) Any individual dissatisfied with any determination under subsection (a) as to—
>
> (A) whether he meets the conditions of section 226 of this Act or section 103 of the Social Security Amendments of 1965, or
>
> (B) whether he is eligible to enroll and has enrolled pursuant to the provisions of part B of this title, or section 1818, or section 1819, or
>
> (C) the amount of benefits under part A (including a determination whether such amount is determined to be zero)
>
> shall be entitled to a hearing thereon by the Secretary to the same extent as is provided in section 205(b) and to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g).
>
> (2) Notwithstanding the provisions of subparagraph (C) of paragraph (1) of this subsection, a hearing shall not be available to an individual by reason of such subparagraph (C) if the amount in controversy is less than $100; nor shall judicial review be available to an individual by reason of such subparagraph (C) if the amount in controversy is less than $1,000....

volving disputes over the administration of part B reimbursements were similarly foreclosed.

In the wake of *Erika*, however, courts have strenuously endeavored to find jurisdiction over various types of challenges to the procedural aspects of the Medicare part B program despite the language of § 1395ff. The Supreme Court itself permitted a constitutional challenge to the hearing process which Congress permitted under § 1395ff. *Schweiker* v. *McClure*, 456 U.S. 188 (1982). Other federal courts have followed suit. *Colonial Penn Insurance Co.* v. *Heckler*, 721 F.2d 431 (3d Cir. 1983); *Starnes* v. *Schweiker*, 715 F.2d 134 (4th Cir. 1983); *Ringer* v. *Schweiker*, 697 F.2d 1291 (9th Cir. 1982), *cert. granted sub nom. Heckler* v. *Ringer*, 103 S. Ct. 3535 (1983).

In this case BC/BSM contends this suit involves simply a dispute over the amount of reimbursement due. In a word, BC/BSM contends, Michigan Academy simply is seeking to have family physicians and their patients moved to the more lucrative specialist screen, boiling down to an argument for an increase in amounts reimbursed. *Erika*, it concludes, should bar this suit outright. This argument, however, is without merit.

While the eventual result of this suit may cause an increase in amounts of reimbursement, that does not necessarily follow. In some cases the result might be an increased amount of reimbursement, and in others, a reduction in reimbursement could occur. Michigan Academy, at bottom line, is challenging the overall mechanism for determining the amounts of reimbursements, not the actual value of any particular reimbursement.

More importantly, unlike the situation in *Erika*, *supra*, there is no indication that Congress intended to preclude our jurisdiction over suits challenging procedural aspects of the Medicare program, despite the language of § 1395ff or § 405(h). Section 1395ff, by its

terms as interpreted by the Supreme Court, precludes judicial review of decisions by the carrier concerning amounts of reimbursements, but is silent on the question of reviewing decisions of the Secretary made in implementing the overall Medicare part B program. *Erika, supra; Starnes, supra.* At the same time, Congress provided for an elaborate administrative review of the carrier's decisions. *See* 42 U.S.C. § 1395ff(a). No similar procedure was developed for review of disputes such as that raised in this case. This court has pointed out that where no mechanism for reviewing administrative decisions is available, courts should be slow to find Congress intended such a bar absent a clear and convincing showing either in the particular act's language or legislative history. *Chelsea Community Hospital, SNF* v. *Michigan Blue Cross Ass'n*, 630 F.2d 1131, 1134 (6th Cir. 1980) (citing *Association of Data Processing Service Organizations* v. *Camps*, 397 U.S. 150 (1970) and *Abbott Laboratories* v. *Gardner*, 387 U.S. 136 (1967)) (jurisdiction exists for reviewing pre-1973 claims disputing the amount of reimbursement under part A of the Medicare Act where no other mechanism for review of such determinations available). With this in mind, we hesitate to bar judicial review over this suit simply because Congress failed to specifically allow for our review in § 1395ff.

BC/BSM and the Secretary argue, however, that even if the language of § 1395ff does not specifically foreclose our review in this case, 42 U.S.C. § 405(h), as incorporated into the Medicare Act by 42 U.S.C. § 1395ii, provides clear support for the contention that Congress intended to preclude all judicial review. They contend that the Supreme Court specifically held that no jurisdiction existed for claims arising under the Social Security Act based on the clear and unambiguous language of this section. *Weinberger* v. *Salfi*, 422 U.S. 749 (1975) (where no other jurisdiction was provided

under the Social Security Act, no judicial review could lie). Since this precise provision was incorporated into the Medicare statute, they argue, and § 1395ff does not specifically provide for judicial review of part B claims, it should be similarly construed in this case. We disagree.

In *Salfi*, *supra*, the Supreme Court specifically referred to the alternative methods available for judicial review of Social Security disputes. *Id.* at 757 (jurisdiction available under § 405(g)). Later Supreme Court decisions have readily followed *Salfi* in barring federal question jurisdiction, but at the same time permitted suits under § 405(g). *Califano* v. *Yamasaki*, 442 U.S. 682, *remanded sub nom. Yamasaki* v. *Harris*, 607 F.2d 329 (9th Cir. 1979); *Mathews* v. *Eldridge*, 424 U.S. 319 (1976).

In *Herzog* v. *Secretary of HEW*, 686 F.2d 1154 (6th Cir. 1982), this court, while barring judicial review of statutory challenges to amounts of reimbursement under part B of the Medicare Act, specifically referred to the elaborate administrative mechanism of § 1395ff as an alternative avenue of review. The court in *Herzog* pointed out that Congress intended to direct such disputes through administrative process rather than overload the federal courts with a flood of small claims. *Id.* at 1158. *See also Erika*, *supra*; *Starnes*, *supra*.

Unlike *Herzog*, however, this dispute involves not a challenge to an individual amount of reimbursement, but instead a challenge to a regulation by the Secretary establishing the procedure under which reimbursement schedules should be determined. Further, Congress did not provide any mechanism to review such decisions of the Secretary in this type of case. In the absence of federal question jurisdiction, therefore, the Secretary apparently would have unbridled discretion to promulgate any regulation he chose. Courts confronted with this dilemma have held that Congress did not intend to pre-

clude federal jurisdiction over such causes. *Colonial Penn Insurance Co., supra; Starnes, supra; Ringer, supra. Cf. Chelsea Community Hospital, supra* (court will entertain suit where no means of reviewing pre-1973 reimbursements under part A of Medicare Act and nothing to indicate Congress intended to foreclose such jurisdiction). Given the presumption favoring judicial review and absent a clear and convincing showing that Congress intended the contrary,[3] we conclude that the district court correctly found federal question jurisdiction under 28 U.S.C. § 1331 to render a decision in this case.

STATUTORY CHALLENGE

Having determined that the district court properly exercised jurisdiction, we turn to the question of whether the Secretary's method of determining reasonable charges for calculating the amount of reimbursements under part B of the Medicare Act in the state of Michigan conformed with the statutory directives of 42 U.S.C. § 1395u(b)(3). After careful analysis of the Medicare Act, its legislative history, and the procedure selected by the Secretary, we find the present methodology impermissible.

Devising procedures for calculating reasonable charges for purposes of reimbursements § 1395u(b)(3) of the Medicare Act specifically requires the Secretary to focus on the customary and prevailing charges for similar services in a locality. The obvious common denominator throughout § 1395u(b)(3) is "similar services." Though not defined by the statute, the language plainly stands for the proposition that once a particular service is determined, all services of a similar nature are to be compensated or reimbursed at the customary,

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[3] *Chelsea Community Hospital, SNF v. Michigan Blue Cross Ass'n, supra* (citing *Ass'n of Data Processing Service Organizations v. Camp, supra; Abbott Laboratories v. Gardner, supra*).

or prevailing rate. The touchstone of this language is that similar services, once determined, are to be compensated equally, regardless of who performs them, at a particular level, determined by the carrier. *See* 42 U.S.C. § 1395u(b)(3); *Alexander* v. *Schweicker* [*sic*], 516 F. Supp. 182 (D. Conn. 1981).

Despite this plain statutory language and without explanation, the Secretary promulgated 42 C.F.R. § 405.504 providing that carriers, in calculating prevailing charges for a particular locality, could develop separate prevailing charges for physicians who were specialists. Such prevailing charges, as defined in § 405.504(2) were to be based on statistics, reflecting customary charging patterns in the locality. In implementing this program in Michigan, the Secretary approved BC/BSM's plan of lumping physicians and non-physicians into three categories, separating specialists from non-specialists except in the case of family physicians. Under this approach, once a physician or other medical provider selected a particular service to perform he chose the appropriate procedure code for the service. Reimbursement for that service was then determined on the basis of the charge screen to which the particular physician or non-allopathic doctor was assigned. Under this approach, a general practitioner would receive a smaller sum than would a specialist for a routine office visit, despite their selections of identical procedural codes.

BC/BSM and the Secretary in an effort to reconcile the obvious inconsistency between the language of § 1395u(b)(3) and the regulation, argue that § 405.504 attempts to further the legislative intent to have reimbursements under the Medicare Act reflect actual charging patterns in the community. They refer to several instances where Congress stated its concern about the possibility of artificially distorting fees charged by physicians through undue interference with physicians'

fees. At trial, however, when questioned about the statistical basis of the Michigan prevailing charge screens, particularly in the separation of family physicians from all other medical specialists (even though they have similar qualifications and perform similar services), no witness could produce actual data demonstrating the significance of such a division. Dr. Boyles, testifying at the trial, stated that the statistical evidence supporting the entire plan was at best "skimpy".[4] Nor could witnesses point to any actual evidence demonstrating that family physicians and non-physicians, such as chiropractors or podiatrists, charged similar amounts for similar services. In fact, the record indicated that the revisions of the prevailing charge screens in 1973 were primarily based on the evolution of the original set of screens which had been basically selected without the benefit of actual data.

We recognize the fact that regulations promulgated by the Secretary must be granted deferential consideration and that we should exercise caution in overturning them. *NLRB* v. *Bell Aerospace Co. Division of Textron, Inc.*, 416 U.S. 267, 274-75 (1974). In this case, in addition to there being no justification for its promulgation, and the obvious inconsistency with the plain language of the Medicare statute, we also hold that this regulation is irrational and is invalid.[5]

Our decision to invalidate the regulation is bolstered by the district court's findings concerning the pernicious impact of this system on the cost of medical care.

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[4] Paul Riesel, Chief of the Physician Practitioner Reimbursement Branch in the Bureau of Program Policy of the Health Care Financing Administration in Baltimore, Maryland, stated that no instructions were given to the carriers for determining prevailing charges and there was no apparent reason for separating family physicians from other specialists with similar qualifications.

[5] Having found this regulation statutorily unsound, we need not address the constitutional issues also raised in this case.

Several witnesses, including former Secretary of HEW Joseph A. Califano, pointed to the severe inflationary impact the system produced. In addition, due to more lucrative reimbursements of specialists, doctors had an added incentive to become specialized and over-utilize technology leading to increased medical costs. At the same time the system, by encouraging specialization, forced patients to seek specialists even for routine health care. Primary care, at the same time, tended to fall off as more and more doctors entered specialty fields. In passing the Health Professions Educational Assistance Act of 1976, Congress clearly expressed its concern for the continued need to protect and encourage primary medical care. *See* Pub. L. No. 90-484, 90 Stat. 2243 (reference to congressional intent to improve maldistribution of physicians and improve availability of primary health care). As was plainly demonstrated at trial, the maldistribution of physicians was significantly enhanced through the use of prevailing charge screens. As a corollary to our holding, therefore, we conclude that these findings by the district court are sufficient to support its determinations that the regulation as applied violates 42 U.S.C. § 1395a, prohibiting infringement of a patient's free choice of a physician.

While we hold today that 42 C.F.R. § 405.504 is invalid, due to its failure to recognize the statutory mandate that similar services be considered identically regardless of who performs them, we think the district court's remedy, adopting sua sponte a single prevailing charge screen for all physicians, goes too far. In a case as complex as this one, we seek the expertise of the government agency to which Congress has assigned responsibility for implementing the statute. Our function on review must be one that is clearly limited to providing correct guidelines within which the knowledge and experience of the specialized agency is called into play. In so doing the policies and goals of the statute may

more closely be pursued and implemented. *Industrial Union Dept.* v. *American Petroleum Institute*, 448 U.S. 607 (1980); *St. Louis University* v. *Blue Cross Hospital Service*, 537 F.2d 283 (8th Cir.), *cert. denied*, 429 U.S. 977 (1976).

We therefore remand this case to the Secretary for reconsideration of the Michigan reimbursement plan under part B of the Medicare program with instructions to consider similar services in an equal manner regardless of who performs that service.

Remanded.

APPENDIX B

UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

No. 81-1202

MICHIGAN ACADEMY OF FAMILY PHYSICIANS, ET AL., PLAINTIFFS-APPELLEES

v.

BLUE CROSS AND BLUE SHIELD OF MICHIGAN AND RICHARD S. SCHWEIKER, SECRETARY OF HEALTH AND HUMAN SERVICES, DEFENDANTS-APPELLANTS.

[Filed Nov. 5, 1984]

ORDER

Before: JONES, Circuit Judge; PECK and BROWN, Senior Circuit Judges.

This case is before this court on remand from the Supreme Court of the United States. The Supreme Court, after granting certiorari, vacated the judgment of this court and remanded for reconsideration in light of *Heckler* v. *Ringer*, 104 S. Ct. 2013 (1984), which was announced subsequent to the filing of our opinion herein.

We conclude that the principles stated by the Supreme Court in *Heckler* v. *Ringer* require us to find that the federal courts lack jurisdiction over the present case, and therefore remand the cause to the United States District Court for the Eastern District of Michigan with instructions to dismiss.

It is so ordered.

ENTERED BY ORDER OF THE COURT

/S/ John P. Hehman

JOHN P. HEHMAN

Clerk

APPENDIX C

UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

No. 81-1202

MICHIGAN ACADEMY OF FAMILY PHYSICIANS, ET AL. PLAINTIFFS-APPELLEES,

v.

BLUE CROSS AND BLUE SHIELD OF MICHIGAN AND RICHARD S. SCHWEIKER, SECRETARY OF HEALTH AND HUMAN SERVICES, DEFENDANTS-APPELLANTS.

[Decided and Filed March 19, 1985]

ORDER

Before: JONES, Circuit Judge; PECK and BROWN, Senior Circuit Judges.

I. Prior Decision and Present Posture of the Case.

In our initial opinion herein, 728 F.2d 326 (6th Cir.), *vacated and remanded,* 105 S.Ct. ___ (1984), we held that a regulation promulgated by the Secretary of Health and Human Services ("Secretary"), 42 C.F.R. § 405.504, violated the language of the Medicare Act as set forth at 42 U.S.C. § 1395u(b)(3) (reimbursement if for "similar services"). In reaching this decision, we held that the district court (and this court) had jurisdiction to hear the challenge brought by the plaintiff, Michigan Academy. Our opinion stated that the challenge to the regulation was based on both statutory and constitutional grounds and was not simply "a challenge to an individual amount of reimbursement." 728 F.2d at 331.[1]

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[1] Michigan Academy contended that the regulation, which authorized Medicare providers such as Blue Cross to set distinct pre-

Following consideration of the remand by the Supreme Court, we entered a similar order remanding the case to the district court for reconsideration in the light of *Heckler* v. *Ringer*, 466 U.S. ___, 104 S.Ct. 2013 (1984). Appellees thereupon petitioned for reconsideration of our remand order, and it is that petition, accompanied by extensive briefs, which is presently before us.

The only issue relevant on remand is that of jurisdiction. In the prior decision we held that federal question jurisdiction existed to hear the challenge under 28 U.S.C. § 1331. As an initial point, we rejected the contention that 42 U.S.C. § 1395ff, which authorizes administrative review of eligibility determinations under Part B of the Medicare Act, implicitly limited review in the federal courts.[2]

We went on to hold that 42 U.S.C. § 405(h), as incorporated in the Medicare Act by 42 U.S.C. § 1395ii, did not specifically prohibit judicial review of a statutory or constitutional challenge to a regulation promulgated under the Medicare Act. 728 F.2d at 330-31. In reaching this decision we distinguished *Weinberger* v. *Salfi*, 422 U.S. 749 (1975) (claims arising under Social Security Act can be reviewed only under § 405(g) procedures) and *Herzog* v. *Secretary*, 686 F.2d 1154 (6th Cir. 1982) (no judicial review for statutory challenges to amount of reimbursement under Part B). 728 F.2d at 331. The basis for the distinction was two-fold: (1) the challenge mustered by Michigan Academy involves not an amount

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vailing charges for identical services when performed by different types of physicians, was contrary to the Medicare Act as well as violative of the Equal Protection and Due Process Clauses of the Constitution.

[2] In reaching its decision in *Heckler* v. *Ringer*, *infra*, the Supreme Court did not rely on § 1395ff. *See United States* v. *Erika, Inc.*, 456 U.S. 201 (1982) (only review of eligibility issues under Part B of Medicare Act is provided by § 1395ff).

of reimbursement but the promulgation of a regulation; and, (2) a contrary decision would preclude any judicial review.

II. Hecker v. Ringer.

In *Ringer, supra*, the Supreme Court, construing § 405(h) as incorporated in the Medicare Act, held that § 405(g)—to the exclusion of 28 U.S.C. § 1331 (federal question jurisdiction)—"is the sole avenue for judicial review for all 'claim(s) arising under' the Medicare Act." Slip op. at 11 (*citing Salfi*, 422 U.S. at 760-61). The court stated that the "claim arising under" language should be construed quite broadly as applying to claims in which "both the standing and the substantive basis for the presentation" of the claim is the Medicare Act. Slip op. at 11-12 (noting that in *Salfi* a constitutional challenge to the statute had been construed as "arising under" the Social Security A[illegible], although in some sense it had also arisen under the Constitution, the "substantive" claim was for benefits).

Ringer is factually distinct from the instant case. *Ringer* involved two sets of claimants for benefits under Part A of the Medicare Act. The claimants sought reimbursement for bilateral carotid body resection; one group had already had the surgery and was requesting reimbursement, while the other group was comprised of individuals who desired but had not had the surgery. The Secretary had issued, however, an administrative instruction that no Medicare payment was to be made for this surgery to relieve respiratory distress. The claimants claimed that the instruction (and a subsequently promulgated regulation to the same effect) was contrary to statute and the Constitution. The group that had had the surgery had not fully exhausted the administrative remedy afforded by § 405(g).

In addition to holding that § 405(g) is the sole avenue for judicial review of claims arising under the Medicare Act, the Court held that the "claims" of both groups

"arose under" the Medicare Act. The Court rejected a distinction between the "substantive claim" for benefits and the "procedural challenge" and held that the procedural claims were "inextricably intertwined" with the claims for benefits. Slip op. at 9-11.

The Court finally considered whether claimant Ringer, who had not yet had the surgery and "did not yet have a 'claim' to present to the Secretary" was barred by § 405(h)'s "claim arising under" bar. The Court held that a "claim for future benefits must be construed as a 'claim arising under' the Medicare Act...." Slip op. at 18-19.

On October 1, 1984, the Supreme Court vacated and remanded our decision herein for reconsideration in light of *Ringer*.

III. Issue on Remand

Did the Supreme Court's decision in *Ringer* dictate a determination that a group of physicians who are not seeking Medicare Part B benefits have no avenue of judicial review?

IV. Discussion

A. Position of Michigan Academy

The principal argument made by Michigan Academy is that *Ringer* is inapplicable to a challenge by Medicare providers to a regulation promulgated by the Secretary, rather than challenging the existence of a payment or a payment level by a Medicare claimant. Michigan Academy notes that a § 405(g) administrative review was not available to it, as it is to individual claimants. Consequently, in the absence of federal question jurisdiction, it has no opportunity for judicial review, a result that is claimed to raise serious constitutional questions.

Although Michigan Academy does not phrase its position in precisely this form, it seems apparent that it is arguing that the challenges it raises on statutory and constitutional grounds are not "claims arising under"

the Medicare Act for purposes of § 405(h). The issue thus created is whether "claims" are limited to substantive requests or apply more broadly to any challenge. Michigan Academy notes that the Supreme Court has itself exercised federal question jurisdiction to hear a constitutional challenge to the administrative review process provided for the Social Security Act. *Schweiker* v. *McClure*, 465 U.S. 118 (1982).

Michigan Academy finally notes that Judge Kinneary, United States District Court for the Southern District of Ohio, subsequent to *Ringer*, held that *Ringer* did not foreclose judicial review to challenges to the Medicare Act where the challenge was advanced by a party other than a claimant for benefits. *Good Samaritan Medical Center* v. *Heckler*, ___ F. Supp. ___ (1984). Michigan Academy contends that this analysis is accurate and should be followed.[3]

B. The Response of the Secretary

The position of the Secretary is that Michigan Academy cannot obtain judicial review of its claims because under *Erika* and *Ringer* judicial review for claims arising under the Medicare Act exist only where there is an explicit grant of jurisdiction. The Secretary cites footnote 4 of *Ringer* as controlling and compelling dismissal of Michigan Academy's action because the Supreme Court rejected the individual Part B claims, even when characterized as collateral constitutional challenges, as more than a claim for benefits. The Secretary argues that the claim of Michigan Academy is, in reality, a claim for benefits.

The Secretary also argues that Michigan Academy's claim that the absence of judicial review is contrary to constitutional principles was rejected by the Supreme Court when it held that *Salfi* did not stand for the principle that § 405(h) must be construed in light of

[3] An appeal to this court has been perfected.

whether jurisdiction exists under § 405(g). The Secretary next argues that there are alternative means of review: (1) a claimant could seek a higher rate for payment to a family physician; (2) Michigan Academy can petition for amendment or repeal pursuant to 5 U.S.C. § 553(e); (3) the Secretary reviews the performance of carriers such as Blue Cross; and (4) the Secretary on occasion reviews an individual determination.

V. Conclusion

The narrow issue before us is one of first impression and presents a close question. The contra arguments of the Secretary are not unpersuasive, but we incline to the time-honored view that a right cannot exist in a vacuum and that for every right there must be a remedy. As we said in our earlier opinion herein, "Given the presumption favoring judicial review and absent a clear and convincing showing that Congress intended the contrary, we conclude that [federal question jurisdiction exists under 28 U.S.C. § 1331]." 728 F.2d at 331. We further conclude, as did Judge Kinneary in *Good Samaritan Medical Center* v. *Heckler, supra,* that the Supreme Court in *Heckler* v. *Ringer, supra,* did not proscribe judicial review to challenges to the Medicare Act where the challenge was made by a party other than a claimant for benefits.

Since for the reasons herein above set forth we conclude that the opinion of the Supreme Court in *Heckler* v. *Ringer, supra,* is not inconsistent with our opinion, the petition for rehearing is granted and it is hereby ordered that our order of November 5, 1984 remanding this cause to the district court with instructions to dismiss be, and it hereby is, rescinded, and that the opinion of this court filed February 23, 1984, 728 F.2d 326, be and it hereby is reaffirmed.

ENTERED BY ORDER OF THE COURT
John P. Hehman, Clerk
/s/ JOHN P. HEHMAN

APPENDIX D

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

Civil Action No. 76-72082
MICHIGAN ACADEMY OF PHYSICIANS, A NON-PROFIT ASSOCIATION, CHARLES FARBER, M.D., GLENN W. HOUSE, M.D., LESTER WEBB, M.D. AND CAROL A. DIEDRICH, PLAINTIFFS

v.

BLUE CROSS AND BLUE SHIELD OF MICHIGAN, AND PATRICIA HARRIS, SECRETARY OF HEALTH AND HUMAN SERVICES, DEFENDANTS

[Filed Dec. 30, 1980]

OPINION

This is an action by plaintiffs seeking judicial review of the action of the Secretary of Health and Human Services in setting reimbursement rates at different levels for certain groups of physicians under Title XVIII of the Social Security Act, Part B, 42 USC 1395, et seq.

Plaintiffs are the Michigan Academy of Family Physicians, a voluntary non-profit association of family physicians, three individual family practitioners, and a Medicare beneficiary.

Defendants are Blue Cross/Blue Shield of Michigan (BC/BSM) a Michigan non-profit corporation which has been designated as the fiscal intermediary and carrier under the Medicare Act for the State of Michigan and

the Secretary of Health and Human Services, the Administrator of the Medicare Program (The Secretary).

At issue is the legality of treating certain family physicians differently from all other physicians in reimbursing them for medical services under Medicare. Such discrimination is illegal for the reasons stated below.

The American Board of Family Practice was established in 1969, and from 1969 until mid-1978 a physician could be qualified to sit for examination by the American Board of Family Practice if he or she had completed a three-year residency program, or if he or she had practiced for a period of six years and completed a minimum of 50 hours continuing education for each of the six years. Effective July 1, 1978, a physician, to be qualified to sit for examination by the American Board of Family Practice, had to have completed a three-year residency program, and, in addition, to take the certification examination. To continue to be board certified, one must retake the examination every six years, and to be either board certified or board eligible one must pursue 50 hours of continuing medical education.

Federal health insurance for the aged, popularly known as Medicare, was enacted by the Congress in 1965, and amended in 1970. The system contains two substantially distant parts, one providing insurance for hospital and related post-hospital services, known as Part A, 42 USC 1395c-1395i-2 (Supp V), the other providing insurance for supplementary medical services, primarily physicians' services, known as Part B. This litigation concerns only Part B of the Medicare Act.

Part B of the Medicare Act is a voluntary health insurance program which operates in a manner similar to private health insurance programs. Eligible individuals enroll in the program and agree to pay a monthly premium established by the Secretary, 42 USC 1395r (b) and (c). The premiums, together with amounts contrib-

uted by the federal government, are deposited in the Federal Supplementary Medical Insurance Trust Fund, which is wholly distinct from the Fund established for Part A. 42 U.S.C. 1395t.

The Medicare Statute provides that Medicare beneficiaries are entitled to reimbursement for medical services provided in the amount of 80 percent of the physician's reasonable charge for covered health services. 48 USC 1395*l*(a)(1)(B). 42 USC 1395u defines "reasonable charge" as the lower of the charges a physician customarily charges for the same service and the prevailing charge in the community for that service. The prevailing charge is statutorily defined as an amount which is equal to the seventy-fifth (75th) percentile of the charges for the same service by other physicians in the same locality.

An individual under Part B who obtains a covered service can pay for this service and request reimbursement at the rate of 80 percent of the "reasonable charge," or assign the right to reimbursement to the person providing this service, who can collect as an assignee of the beneficiary, 42 USC 1395u(b)(3)B(ii). By accepting assignment, a physician agrees to demand no more of a patient that [*sic*] the reasonable charge determined by the Secretary. Accordingly, the patient is only responsible for the 20 percent of the reasonable charge not paid for by Medicare. A physician who does not accept assignment has no statutory limitation on the amount he or she may charge a Medicare beneficiary. However, the physician may not bill Medicare directly, but rather must recover directly from the beneficiary for the services performed.

Upon the inception of the Medicare program, and to this day, BC/BSM has neither developed a procedure to determine what types of professional services are similar to others for purposes of establishing prevailing charges in accordance with 42 USC 1595u(b)(3), nor

carried out a statistical study to determine different types of providers' actual charge patterns for particular services, pursuant to 42 C.F.R. § 405.504(b). Instead, BC/BSM in 1966 established three "screens" to determine the prevailing fee calculations for Medicare "reasonable charge" determination in Michigan. One screen contained board certified and board eligible internists for hospital visits; another screen contained board certified and board eligible specialists, and board certified and board eligible internists for services other than inpatient hospital visits; and the third screen consisted of board certified and board eligible family physicians, nonboard eligible family physicians and various nonphysician groups, such as podiatrists, chiropractors, and dentists.

In February 1973, BC/BSM redefined the three screens. The screens, as they still exist today, were realigned as follows: Screen one is for general practitioners or nonspecialists. Included in this screen are DOs and MDs who are general practitioners, non-board certified family practitioners, chiropractors, podiatrists, and dental surgeons. Screen two is made up of internists for inpatient hospital services only. Contained in this screen are DOs and MDs who are board certified and non-board certified internists for inpatient hospital services only. Screen three is a specialists' screen. It is made up of DOs and MDs who are board certified family practitioners, and board certified and non-board certified specialists. Physicians who engage in a group practice, and who agree to bill under a group number, are placed within the specialists' screen for purposes of determining reasonable charges in Michigan, regardless of the qualification of the physicians in the group.

From these three groupings, a 75th percentile was established, and thus, in determining the prevailing fee for an office visit, the charges of all the physicians

within the so-called "specialty screen" would be lumped together to determine the "reasonable charges." Once a physician is classified as either a specialist or a non-specialist by the carrier, all billings submitted for all types of procedures performed by that physician are priced against prevailing charges applicable to the screen in which he or she is placed. The significance of this procedure with respect to the present case is that the 1973 modification of the screens placed board-certified family physicians in the so-called specialists' screen. Family physicians who were not board certified, whether or not they had completed a certified residency program in family practice, remained in the GPN, or non-specialty screen. These family physicians constitute the only physicians not placed within a specialists' screen, and they are the only physicians whose reasonable charges are determined in part by the charges of non-physicians, such as podiatrists and chiropractors.

At issue is the validity of prevailing charge screens used by BC/BSM as an upper limit on reimbursable charges for physicians' services under Part B.

Plaintiffs claim that there is no factual basis whatever to justify treating family physicians differently from all other physicians, and not only does the discrimination against them have no rational basis theoretically, it makes less sense in application. Even defendants have admitted at trial that there is no rationale for treating board eligible family physicians as non-specialists. Plaintiffs further contend that the change from a dual screen prevailing fee concept to a one screen prevailing fee concept would result in a lower payment for services, render the Medicare Program more efficient, and would more correctly bring into play market forces.

Plaintiffs contend that the creation and maintenance of special family physician differentials for purposes of

determining reasonable charges violates the Fifth Amendment, that the maintenance of the dual reimbursement screen violates plaintiffs' right to procedural due process in that it deprives the plaintiffs of property rights based upon an irrebuttable presumption that plaintiffs' physician services are worth less than, and are not similar to, all other physician services, presumptions not necessarily nor universally true in fact; and that defendants' creation and maintenance of separate reimbursement screens, whereby family physicians are segregated from all other allopathic physicians for determination of Medicare reimbursement violates the express provisions of 42 USC 1395u(b)(3) and the applicable regulations, 42 C.F.R. 405.504(b).

Indeed, the evidence bears out plaintiffs' contention. The testimony in the case showed that there was no factual basis whatever to justify treating family physicians differently from all other physicians, either at the onset of the medical care program or presently. And, as is clear from a review of the screening procedure itself, BC/BSM in its private insurance does not distinguish between specialists and non-specialists, but rather pays a certain amount for the service regardless of who furnishes that service.

42 USC 1395u(b)(3) sets forth the obligation of the Secretary and carrier under Part B of the Medicare program. It provides, in pertinent part:

> "In determining the reasonable charge for services for purposes of this paragraph, there shall be taken into consideration the customary charges for *similar services* generally made by the physician or other person furnishing such services, as well as the prevailing charges in the locality for *similar services*. No charge may be determined to be reasonable in the case of bills submitted or requests for payment made under this part after December 31, 1970, if it exceeds the higher of (i), the prevailing charge recognized by the carrier and found ac-

ceptable by the Secretary for *similar services* in the same locality in administering this part on December 31, 1970, or (ii) the prevailing charge level that, on the basis of statistical data and methodology acceptable to the Secretary, would cover 75 percent of the customary charges made for *similar services* in the same locality during the last preceding calendar year . . ." (Emphasis Added)

Further, 42 USC 1395(a) provides that nothing in the Medicare Act shall be construed to authorize the federal government or its agents to supervise or control the practice of medicine or the manner in which medical services are provided, or the selection, tenure, or compensation of officers or employees of health care providers, or the selection of medical care providers by beneficiaries.

The applicable regulation under 42 USC 1395 is 42 CFR 405.504(b). This regulation provides:

> "The range of prevailing charges in a locality may be different for physicians or other persons who engage in a specialty practice or service than for others. Existing differentials in the level of charges between different kinds of practice or service could, in some localities, lead to development of more than one range of prevailing charges for application by the carrier in its determinations of reasonable charges. Carrier decisions in this respect should be responsive to the existing patterns of charges by physicians and other persons who render covered services, and should establish differentials in the levels of charges between different kinds of practice or service only where in accord with such patterns."

Plaintiffs contend that defendants have never used the test of similar services as a basis for determining any physician's prevailing charge, and that the current reimbursement system of BC/BSM deviates from the statutory directives. They point out that for purposes

of determining any particular physician's "prevailing charge," defendant BC/BSM determines whether the physician is a "specialist" or "general practitioner" under its own definition. Once this decision or definition is rendered, that particular physician will receive reimbursement as the same rate as all other "specialists" or "general practitioners," no matter what type of procedure is being performed. Plaintiffs argue that no recognition of similarity of services exists in defendant's reimbursement decisions, even though a similarity of service is a standard by which such distinctions are to be made.

It is clear that the statute, 42 USC 1395u(b)(3) uses as the statutory scheme the customary charge of physicians for similar services in a specific locality. The statute further provides that nothing in the Medicare Act shall be construed as authorizing the federal government or its agent to supervise or control the practice of medicine or the manner in which medical services are provided, or the selection of Medicare providers by beneficiaries.

20 C.F.R. 405.504(b) authorizes a carrier to separate customary charges for similar services in computing the 75th percentile prevailing fee reasonable charge ceiling. In so doing, the regulation conflicts with the statute, which mandates that customary charges of physicians for similar services be the test for reimbursement.

The maintenance of three screens in the State of Michigan clearly violates 42 USC 1395(a) because it tends to influence the patient's choice of a physician, and reduces Medicare recipients' reimbursement solely by virtue of their choice of the type of physician to perform a particular medical service. The effect of the maintenance of these screens is to cause a Medicare recipient to go to a specialist for a particular service, or, if the recipient is not sophisticated enough to know the provisions, to cause him or her to suffer a lesser reim-

bursement than a person who had chosen a specialist to perform the type of medical service required. Even 20 C.F.R. 405.504(b) requires that any distinction between types of physicians for purposes of establishing prevailing fee schedules must be based upon a statistically valid analysis of the range of charges. The record in this case failed to show any statistically valid analysis of the billings of allopathic family physicians as compared with other types of family physicians.

There is no basis to justify the segregation of allopathic family physicians from all other types of physicians. Such segregation is not rationally related to any legitimate purpose of the Medicare statute. To lump MDs who are family physicians, but who have chosen not to become board certified family physicians for whatever motive, with chiropractors, dentists, and podiatrists for the purpose fo determining Medicare reimbursement defies all reason.

The effect of this can be dramatically shown in the case of Plaintiff Carole A. Diedrich, a Medicare recipient who has been disabled and has been a recipient since 1975. Her physician is Philip Lange, M.D., a family physician who has practiced in Lansing, Michigan, for approximately 23 years. Dr. Lange sees patients ranging in age from newborns through the very old, and treats a vast majority of medical conditions. He is on the staffs of St. Lawrence Hospital, Sparrow Hospital, and the Ingham County Medical Center. He is a graduate of the Wayne State University Medical School, and did a one-year internship and one-year residency in general medicine at St. Lawrence Hospital. He is an instructor at Michigan State University, and teaches students in family medicine. He is neither board eligible nor board certified by the American Board of Family Practice. For most procedures, Dr. Lange does not accept assignment from Medicare for

certain office calls, and charges patients $50 for a comprehensive examination, and $18 for routine office visit.

Where a physician does not accept an assignment, the patient is responsible for whatever charge the physician renders, the patient receiving reimbursement from Medicare in the amount of 80 percent of the reasonable fee, as determined by the carrier. The prevailing fee limitation for 1980 in the Lansing area is as follows: initial comprehensive visit, non-specialist $25, specialist $50; follow-up office visit non-specialist $10.70, specialist $12.30. Solely as a result of Mrs. Diedrich's choice of Philip Lange as her treating physician, she, while paying the same premium as other Medicare recipients, received less coverage for services performed than had she chosen a physician defined as a "specialist."

This example dramatically shows the effect of the screens established by BC/BSM in the reimbursement of Medicare recipients, and is the heart of plaintiffs' complaint in this action. Simply stated, Mrs. Diedrich, while paying the same premium as other Medicare recipients, receives less coverage for services performed for primary care because she goes to Dr. Lange than she would have received had she chosen a physician defined as a specialist.

The establishment of separate screens segregating non-board certified family physicians from all other physicians clearly is violative of the Medicare Act. To the extent that 20 C.F.R. 405.504(b) authorizes the screens set up by the defendants, that regulation is invalid.

Because the Court has found that the actions of defendants violate the Medicare statute, 42 USC 1395 et seq., it need not consider the constitutional arguments raised by plaintiffs.

A mandatory injunction will issue, directing defendants to provide that all physicians be included in a

single screen, separate from the screen for chiropractors, podiatrists, and dentists.

Plaintiffs may tax costs. A judgment may be entered in accordance with this opinion, which shall constitute the findings of fact and conclusions of law required by FRCP 52.

/s/ _____

HORACE W. GILMORE
United States District Judge

APPENDIX E

UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

No. 81-1202

MICHIGAN ACADEMY OF FAMILY PHYSICIANS, ET AL., PLAINTIFFS-APPELLEES,

v.

BLUE CROSS AND BLUE SHIELD OF MICHIGAN AND RICHARD S. SCHWEIKER, SECRETARY OF HEALTH AND HUMAN SERVICES, DEFENDANTS-APPELLANTS

[Filed Feb. 23, 1984]

JUDGMENT

BEFORE: JONES, Circuit Judge; PECK AND BROWN, Senior Circuit Judges.

ON APPEAL from the United States District Court for the Eastern District of Michigan.

THIS CAUSE came on to be heard on the record from the said District Court and was argued by counsel.

ON CONSIDERATION WHEREOF, It is now here ordered and adjudged by this court that this case is remanded to the Secretary for proceedings not inconsistent with this opinion.

Each party is to bear its own costs on the appeal.

ENTERED BY ORDER OF THE COURT

/S/ _____
JOHN P. HEHMAN,
Clerk

A TRUE COPY.
Attest:

/S/ _____
TOM ENNIGNUS
Deputy Clerk

APPENDIX F

UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

No. 81-1202

MICHIGAN ACADEMY OF FAMILY PHYSICIANS, ET AL., PLAINTIFFS-APPELLEES,

v.

BLUE CROSS AND BLUE SHIELD OF MICHIGAN, ET AL., DEFENDANTS-APPELLANTS

[Filed May 30, 1985]

ORDER

BEFORE: JONES, Circuit Judge, PECK and BROWN, Senior Circuit Judges

The Court having received a petition for rehearing en banc, and the petition having been circulated not only to the original panel members but also to all other active judges of this Court, and less than a majority of the judges having favored the suggestion, the petition for rehearing has been referred to the original hearing panel.

The panel has further reviewed the petition for rehearing and concludes that the issues raised in the petition were fully considered upon the original submission and decision of the case. Accordingly, the petition is denied.

ENTERED BY ORDER OF THE COURT

/S/ John P. Hehman

JOHN P. HEHMAN, *Clerk*

APPENDIX G

STATUTORY PROVISIONS AND REGULATIONS INVOLVED

1. 28 U.S.C. 1331 provides:

The district courts shall have original jurisdiction of all civil actions arising under the Constitution, laws, or treaties of the United States.

2. Section 205(h) of the Social Security Act, 42 U.S.C. 405(h), provides:

The findings and decisions of the Secretary after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the Secretary shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the Secretary, or any officer or employee thereof shall be brought under sections 1331 or 1346 of title 28 to recover on any claim arising under this subchapter.

3. Section 1842 of the Social Security Act, 42 U.S.C. 1395u, provides in relevant part:

> (a) Authority of Secretary to enter into contracts with carriers
>
> In order to provide for the administration of the benefits under this part with maximum efficiency and convenience for individuals entitled to benefits under this part and for providers of services and other persons furnishing services to such individuals, and with a view to furthering coordination of the administration of the benefits under part A and under this part, the Secretary is authorized to enter into contracts with carriers, including carriers with which agreements under section 1395h of this title are in effect, which will perform some or all of

the following functions (or, to the extent provided in such contracts, will secure performance thereof by other organizations); and, with respect to any of the following functions which involve payments for physicians' services or a reasonable charge basis, the Secretary shall to the extent possible enter into such contracts:

(1)(A) make determinations of the rates and amounts of payments required pursuant to this part to be made to providers of services and other persons on a reasonable cost or reasonable charge basis (as may be applicable);

* * * * *

(b) Applicability of competitive bidding provisions; findings as to financial responsibility, etc., of carrier; contractual duties imposed by contract

* * * * *

(3) Each such contract shall provide that the carrier—

(A) will take such action as may be necessary to assure that, where payment under this part for a service is on a cost basis, the cost is reasonable cost (as determined under section 1395x(v) of this title;

(B) will take such action as may be necessary to assure that, where payment under this part for a service is on a charge basis, such charge will be reasonable and not higher than the charge applicable, for a comparable service and under comparable circumstances, to the policyholders and subscribers of the carrier, and such payment will (except as otherwise provided in section 1395gg(f) of this title) be made—

(i) on the basis of an itemized bill; or

(ii) on the basis of an assignment under the terms of which (I) the reasonable charge is the full charge for the service and (II) the physician or other person furnishing such service agrees not to charge for such service if pay-

ment may not be made therefor by reason of the provisions of paragraph (1) of section 1395y(a) of this title, * * *

* * * * *

(C) will establish and maintain procedures pursuant to which an individual enrolled under this part will be granted an opportunity for a fair hearing by the carrier, in any case where the amount in controversy is $100 or more, when requests for payment under this part with respect to services furnished him are denied or are not acted upon with reasonable promptness or when the amount of such payment is in controversy;

* * * * *

(F) will take such action as may be necessary to assure that where payment under this part for a service rendered is on a charge basis, such payment shall be determined on the basis of the charge that is determined in accordance with this section on the basis of customary and prevailing charge levels in effect at the time the service was rendered or, in the case of services rendered more than 12 months before the year (ending on June 30) in which the bill is submitted or request for payment is made, on the basis of such levels in effect for the 12-month period preceding such year;

and shall contain such other terms and conditions not inconsistent with this section as the Secretary may find necessary or appropriate. In determining the reasonable charge for services for purposes of this paragraph, there shall be taken into consideration the customary charges for similar services generally made by the physician or other person furnishing such services, as well as the prevailing charges in the locality for similar services. No charge may be determined to be reasonable in the case of bills submitted or requests for payment made under this part after December 31, 1970, if it exceeds the higher of (i) the prevailing charge rec-

ognized by the carrier and found acceptable by the Secretary for similar services in the same locality in administering this part on December 31, 1970, or (ii) the prevailing charge level that, on the basis of statistical data and methodology acceptable to the Secretary, would cover 75 percent of the customary charges made for similar services in the same locality during the last preceding calendar year elapsing prior to the start of the twelve-month period (beginning July 1 of each year) in which the service is rendered.* * *

4. Section 1869(a) and (b) of the Social Security Act, 42 U.S.C. 1395ff(a) and (b), provides:

(a) Entitlement to and amount of benefits

The determination of whether an individual is entitled to benefits under part A or part B, and the determination of the amount of benefits under part A, shall be made by the Secretary in accordance with regulations prescribed by him.

(b) Appeal by individuals

(1) Any individual dissatisfied with any determination under subsection (a) of this section as to—

(A) whether he meets the conditions of section 426 or section 426a of this title, or

(B) whether he is eligible to enroll and has enrolled pursuant to the provisions of part B of this subchapter, or section 1395i-2 of this title, or section 1819, [footnote omitted] or

(C) the amount of benefits under part A (including a determination where such amount is determined to be zero)

shall be entitled to a hearing thereon by the Secretary to the same extent as is provided in section 405(b) of this title and to judicial review of the Secretary's final decision after such hearing as is provided in section 405(g) of this title.

(2) Notwithstanding the provisions of subparagraph (C) of paragraph (1) of this subsection, a hearing shall not be available to an individual by reason of such subparagraph (C) if the amount in controversy is less than $100; nor shall judicial review be available to an individual by reason of such subparagraph (C) if the amount in controversy is less than $1,000.

5. 42 C.F.R. 405.504(b) provides:

> *Variation in range of prevailing charges.* The range of prevailing charges in a locality may be different for physicians or other persons who engage in a specialty practice or service than for others. Existing differentials in the level of charges between different kinds of practice or service could, in some localities, lead to the development of more than one range of prevailing charges for application by the carrier in its determinations of reasonable charges. Carrier decisions in this respect should be responsive to the existing patterns of charges by physicians and other persons who render covered services, and should establish differentials in the levels of charges between different kinds of practice or service only where in accord with such patterns.

85-225

Supreme Court, U.S.
FILED
SEP 6 1985
JOSEPH F. SPANIOL, JR.
CLERK

NO.

In The

Supreme Court of the United States

October Term, 1985

MARGARET M. HECKLER, SECRETARY OF HEALTH AND HUMAN SERVICES, ET AL.,
Petitioners

v.

MICHIGAN ACADEMY OF FAMILY PHYSICIANS, ET AL.
Respondents

BRIEF IN OPPOSITION TO THE PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

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QUESTIONS PRESENTED

Did the Court of Appeals correctly conclude that 42 U.S.C. Sec. 1395ff and 42 U.S.C. Sec. 405(h) do not deprive Respondents of a judicial forum for redress of their substantial statutory and constitutional claims?

If it is determined that 42 U.S.C. Sec. 1395ff and 42 U.S.C. Sec. 405(h) do authorize an agency of the federal government to violate the Medicare statute or the Fifth Amendment to the United States Constitution with no forum for those affected to take redress, does such lack of forum violate the United States Constitution?

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STATEMENT

1. Background

This case involves a challenge to a regulation promulgated by the Department of Health and Human Services which permitted differential treatment to certain allopathic (M.D.) family physicians (and their patients) versus all other allopathic physicians (and their patients) under the Medicare Program. The differential treatment invalidated by both the trial court and the Court of Appeals is implemented through the creation and maintenance of separate fee screens which place family physicians in the same fee screen as podiatrists, chiropractors, and dentists while physicians with different specialties were placed in a separate specialty fee screen. Respondents alleged in their complaint that the differential treatment of family physicians compared to all other types of physicians violated both substantive due process under the Fifth Amendment to the United States Constitution and the Medicare statute, specifically 42 U.S.C. 1395a (which guarantees a free choice of physicians by patients) and 42 U.S.C. Sec. 1395u(b)(3) (which requires that prevailing fee limitations be based upon similar services). No monetary relief was requested, Respondents requesting a finding that the maintenance of separate fee screens by Petitioner in administering the Medicare Program violated the Medicare statute and the Fifth Amendment. As discussed, infra, it is essentially the position of the Petitioners that Respondents have no forum whatsoever to address their statutory and constitutional claims.

2. The Medicare Act

Petitioners' description of the Medicare Program is sufficient and will not be repeated here in detail, except for those provisions that relate directly to the present case or those provisions not discussed by Petitioners. Under Part B of the Medicare Program the Secretary is authorized to enter into contracts with private insurance companies for its administration. 42 U.S.C. 1395u. Part B of the Medicare Program concerns services provided by physicians,

podiatrists, chiropractors, and dentists. In contrast, Part A of the Medicare Program provides coverage for institutional care. The distinction between Parts A and B of Medicare are relevant to the present appeal to the extent that it serves as a point of contrast for both past precedents and the review mechanisms provided under each Part.

Under Part A, determinations of both "entitlement to benefits" and "amount of benefits" are made by the Secretary, 42 U.S.C. Sec. 1395ff(a). Under Part B the determination of "entitlement to benefits" is made by the Secretary. Under Part A, an individual dissatisfied with either an eligibility or amount of benefits determination is entitled to a hearing by the Secretary and to judicial review of the Secretary's final decision pursuant to 42 U.S.C. 405(g). In contrast, 42 U.S.C. Section 1395ff(b) provides for a hearing by the Secretary and judicial review of the Secretary's final decision only where an individual is dissatisfied with entitlement determinations under Part B.

The hearing rights of individuals dissatisfied with an "amount of benefits" determination under Part B consist of a hearing before a carrier selected by the agency to administer the Medicare Program, here Blue Cross and Blue Shield of Michigan. Specifically, Sec. 1395u(b)(3)(C) provides that an individual will be granted an opportunity for a "fair hearing by the carrier" in cases of controversy over $100.00 with regard to services furnished or not acted upon with reasonable promptness.[1] Section 405(h) generally indicates that the findings of the Secretary following a hearing are binding and no further review (judicial or otherwise) is per-

---

[1] This statute states as follows:

> (3) Each such contract shall provide that the carrier—
>
> (C) will establish and maintain procedures pursuant to which an individual enrolled under this part will be granted an opportunity for a fair hearing by the carrier, in any case, where the amount in controversy is $100 or more, when requests for payment under this part with respect to services furnished him are denied or are not acted upon with reasonable promptness or when the amount of such payment is in controversy.

missible unless otherwise provided. Under the general provisions of the Social Security Act, a hearing by the Secretary (and judicial review thereafter) is accorded by 42 U.S.C. Sec. 405(g). However, 42 U.S.C. Sec. 1395ii fails to make Sec. 405(g) applicable to the Medicare Act.

Petitioners have gone to great lengths in their Petition for Writ of Certiorari to characterize Respondent's cause of action as a "claim for benefits." The assertion that Plaintiff's cause of action is an "amount of benefit case", however, is repudiated by Petitioners' own regulations. The fair hearing conducted by the carrier is controlled by regulations promulgated by the Secretary and certain provisions of the "Carrier's Manual."[2] The types of challenges that may be heard by the carrier are carefully delineated by regulation, 42 CFR 405.801. The regulations provide for a hearing when a party is dissatisfied with a determination denying a request for payment, the amount of payment or where the request for payment is not being acted upon with reasonable promptness. A party is then given a right to a "fair hearing" (42 CFR 405.820) conducted by a hearing officer designated by the carrier. (42 CFR 405.823). The jurisdiction of the hearing officer is carefully circumscribed by regulations as follows:

> The hearing officer in exercising the authority to conduct a hearing on this Section 1842(b)(3)(c) of the Act is to comply with all the provisions of Title XVIII of the Act and regulations issued thereunder, as well as with policy statements, instructions and other guides issued by the Health Care Financing Administration in accordance with the Secretary's agreement with the carrier. 42 CFR 405.860.

---

[2] The Carrier's Manual was compiled by the Health Care Financing Administration. Its declared purpose is to serve as "practical operation instructions needed by the contractors responsible for the administration of the supplementary and medical insurance program — Part B Medicare." (forward to Carrier's Manual).

The restrictions imposed upon the hearing officer's jurisdiction are made even more explicit by the Carrier's Manual, the compilation of guidelines a hearing officer is required by the above regulation to follow. Section 12016 of the Manual states:

> Authority — The HO occupies a significant position in the administrative appeals process affording dissatisfied individuals with hearing rights as provided in Section 1842 (b)(3)(C) of the Act. Authority of the HO is limited to the extent that he must comply with all provisions of Title XVIII of the Act and regulations issued thereunder, as well as with HCFA rulings, general instructions, and other guides issued by HCFA with the Medicare Bureau. *The HO does not have the prerogative of overruling the provisions of the law or of interpreting them in a way different than that of the Medicare Bureau when he is in disagreement with their intent; nor may he use hearing decisions as a vehicle for commenting upon the legality, constitutional or otherwise, of any provision of the Act or regulations relevant to the Medicare Program.* (emphasis added)

3. Proceedings

Respondents commenced this action on October 8, 1976 alleging that the differential treatment of family physicians, compared to all other types of physicians in the State of Michigan, violated both substantive due process under the Fifth Amendment to the United States Constitution and the Medicare Statute. No monetary relief was requested, Plaintiffs seeking prospective relief in the form of an injunction prohibiting Petitioners from treating family physicians differently from other physicians and a finding that the maintenance of separate fee screens by Petitioners violated the Medicare statute and the Fifth Amendment. Respondents requested that the court enjoin Petitioners from treating family physicians differently from other physicians for purposes of the Medicare Program.

Respondents' statutory claim based upon 42 USC Sec. 1395u(b)(3)[3] asserted that, contrary to the Medicare Act's mandate that "similar service" be the basis for determining reasonable charges, the Secretary had promulgated a regulation which authorized the carrier to segregate and group physicians on the basis of specialty practice for the purpose of developing reimbursement screens used for all types of procedures, including primary care procedures, thereby according different payment for similar service. See 42 CFR 405.504(b)[4]

Prior to suit, in October, 1974, Respondents requested a hearing with the Carrier to provide the individual Respondents with an opportunity to demonstrate that Respondent-physician's training and experience were such as to warrant

---

[3] 42 USC Sec. 1395u(b)(3) states as follows:

"In determining the reasonable charge for services for purposes of this paragraph, there shall be taken into consideration the customary charges for similar services generally made by the physicians or other person furnishing such service, as well as the prevailing charge in the locality for similar services. No charge may be determined to be reasonable in the case of bills submitted or request for payment made under this Part after December 31, 1980, if it exceeds the higher of (i) the prevailing charge recognized by the carrier and found acceptable by the Secretary for similar services in the same locality in administering this part on December 31, 1970, or (ii) a prevailing charge level that, on the basis of statistical data and methodology acceptable to the Secretary, would cover seventy-five (75%) percent of the customary charges made for similar services in the same locality during the last preceding calendar year . . ."

[4] This regulation provides:

"The range of prevailing charges in a locality may be different for physicians or other persons who engage in a specialty practice or service than for others. Existing differentials and the level of charges between different kinds of practice or service could, in some localities, lead to development of more than one range of prevailing charges for application by the carrier in its determination of reasonable charges. Carrier decisions in this respect shall be responsible to the existing patterns of charges by physicians and other persons who render covered services and should establish differentials in the level of charges between different kinds of practice or service only where in accord with such patterns."

equal payment for primary care procedures. In December, 1974, the Carrier responded to the request indicating that Respondents could utilize a peer review procedure. In March, 1975, the Carrier further clarified the scope of the hearing by indicating that an adjudication as to the reasonableness of the specialty differential could not be involved and the Carrier would accept no adjudication which eliminated such a differential. Additionally, Respondent-patient, without counsel, protested the prevailing fee determination as to services performed by her treating physician and was notified by the Carrier that she was without recourse and nothing could be done.

Prior to trial, the Secretary moved to dismiss Respondents' Complaint for lack of jurisdiction as to the statutory claim and as to the constitutional claim on the basis that the constitutional claim was insubstantial. In December, 1977, the Secretary's motion was denied by the Honorable James Churchill in a memorandum opinion which noted:

> I am influenced by the improbability that Congress would intentionally authorize an administrative agency to delegate to a private contractor the power to violate the Constitution of the United States in the name of the United States without recourse.

Following trial on the merits, the district court held that the Carrier had not developed a procedure to determine what types of professional services were similar and that the classification scheme of 42 CFR 405.504(b) was plainly inconsistent with the Medicare statute which "mandates the customary charges of physicians for similar services to be the test for reimbursement." 502 F. Supp. at 755.

The district court further found that this classification scheme violated yet another provision of the Medicare statute, 42 USC Sec. 1395a, because it tended to influence a beneficiary's choice of physician and reduced that benefici-

ary's reimbursement solely by virtue of the choice of the type of physician to perform a particular medical service.[5]

Since the district court found the Secretary's and Carrier's actions to be a clear violation of the Medicare Act, it did not consider the constitutional arguments advanced by Respondent, but did state that "such segregation is not rationally related to a legitimate purpose of the Medicare statute." 502 F. Supp. at 755.

By way of remedy, the district court issued a mandatory injunction directing the Petitioners to provide a single screen for all physicians separate from a screen for chiropractors, podiatrists and dentists.

The court of appeals affirmed the decision of the district court, both in terms of subject matter jurisdiction and the substantive merits of the lawsuit. However, the court determined that the remedy adopted by the district court went too far. The court of appeals remanded the case to the Secretary for reconsideration of the reimbursement plan with the proper focus of "similar service."

As to jurisdiction, the Court of Appeals recognized that this Court's decision in *United States* v *Erika*, 456 U.S. 201 (1982), held that Congress clearly and convincingly intended no judicial review of amount of benefit cases. However, after a review of the applicable statutes and case law, the court concluded that jurisdiction did exist under the particular circumstances of this case.

---

[5] The district court demonstrated the financial impact of this classification scheme by focusing on the effect upon respondent-patient. Respondent-patient was a Medicare recipient whose treating physician was a family physician who had been in practice for twenty-three (23) years. While being on staff at three different hospitals and while being an instructor at Michigan State University, this physician was neither board eligible nor board certified by the American Board of Family Practice. The district court noted that solely as a result of selecting this physician (a choice protected pursuant to 42 USC Sec. 1395a) respondent-patient was in fact paying more for her physician visits and treatments although paying the same premium as another recipient who may have chosen a physician defined by the Petitioner as a "specialist."

As to the merits of Respondents' case, the Court of Appeals found that the "touchstone" of 42 USC 1395u(b)(3) is "similar service" and that there was an obvious inconsistency between this statute and the disputed regulation. The Court of Appeals found the regulation "irrational" and "invalid." 728 F.2d at 329. Because the regulation was statutorily unsound, the court did not address the constitutional issues raised in the case. 728 F. 2d at n. 5. See *Hagans* v *Levine*, 415 U.S. 534 (1974).

Following a remand on a petition for rehearing, the U. S. Court of Appeals for the Sixth Circuit reaffirmed its position on jurisdiction on March 19, 1985. Contrary to statements contained in the Petition for Writ of Certiorari, however, the U. S. Court of Appeals in neither of its decisions ignored the precedent of this Court. The fact is the initial opinion cited and analyzed in detail *United States* v *Erika, supra*, and the subsequent opinion, went into great depth as to the application of *Ringer, supra*, and noted that in *Ringer, supra*, claimants had not exhausted the administrative remedy afforded by Sec. 405(g). The court further noted that no 405(g) administrative review was available to Respondents in this case, and that the Supreme Court has itself exercised federal jurisdiction to hear constitutional challenge to the administrative review process provided by the Social Security Act. *Schweiker* v *McClure*, 456 U.S. 188 (1982). In holding for Respondents, the court indicated that the arguments of the Secretary were not unpersuasive, but the U. S. Court of Appeals was inclined to follow the time honored view that a right cannot exist in a vacuum and that for every right there must be a remedy.

The suggestion of the Petitioners that the decision of the U. S. Court of Appeals threatens to reintroduce the regime of uncertainty and widespread litigation on Part B issues that prevailed prior to *Erika* ignores the Sixth Circuit's decision in *Herzog* v *Secretary*, 682 F2d 121 (6th Cir, 1982), a case noted and distinguished by the Sixth Circuit. In *Herzog*, the claimants disputed the fact that chelation therapy was held by the Secretary to be non-reimbursable.

The claimants sought and were afforded an administrative review of this adverse decision. They subsequently filed suit in federal court. The Court of Appeals, relying extensively on this Court's opinion in *Erika* ruled that federal court jurisdiction did not exist to hear the claimants' amount of benefit case.

Contrary to the assertion of Petitioners, the Sixth Circuit's decision in this case is limited to statutory and constitutional claims for which there is no administrative forum available.

This is the Petitioners' second Petition for Writ of Certiorari involving this case. In both cases, Petitioners have declined to seek review of the Court of Appeals decision on the merits. Nevertheless, in the body of Petitioners' arguments they see fit to address the merits of the case on a limited basis. For example, in footnote 2 of the Petition it is stated that the government acknowledged in proceedings in the district court that board eligible family physicians should have been included in the specialist category. In fact, while the government did concede at trial that it had no basis to treat board eligible family physicians as non-specialists, the government refused an invitation of the court to place such physicians in the specialty screen. See Appendix A. Furthermore, the government repeatedly characterizes 42 USC 1395u(b)(3) as a requirement that the Carrier "take into consideration" similar services in determining payment ceilings. Without so stating, the government appears to imply that the Carrier has the option of taking similar services into consideration, but may decline to follow similarity as its test. This inference ignores the balance of the statutory provision noted in footnote 3 of this Brief, which states in no uncertain terms that no charge may be determined to be reasonable which exceeds the 75th percentile of charges for similar services.

In essence, by relying only on the jurisdictional issues and ignoring the merits of this case, the government is seeking a determination that Respondents have no recourse to

address statutory and constitutional violations. Respondents, prevailed on a statutory claim in both the district court and the circuit court, and the government conceded that it had no rationale for its actions, at least as it pertained to a portion of Respondents' claim.

In its petition, the government has also glossed over the fact Respondents have raised a serious constitutional claim which the Honorable James Churchill found had sufficient merit to withstand a motion for summary judgment, and which the Honorable Horace Gilmore declined to rule upon, having found the statutory violation but characterized the Petitioners' position as not related to any legitimate purpose in the Medicare statute and defying all reason. 502 F Supp at 755. Furthermore, the U. S. Court of Appeals, in both of its opinions, recognized Respondents' constitutional claims, noting that since it had found the regulations statutorily unsound, the constitutional issues need not be addressed. Nowhere in Petitioners' Petition for Writ of Certiorari are Respondents' constitutional claims even acknowledged. Thus, by ignoring Respondents' complaint, the Petition avoids grappling with the issue of denial of any forum whatsoever to address substantial constitutional issues.

Finally, the government's petition ignores the impact of the U. S. Court of Appeals' reversal of the lower court's decision to the extent it mandated a particular relief. Rather, the U. S. Court of Appeals simply remanded the case to the Secretary for reconsideration of the Michigan reimbursement plan under Part B of the Medicare Program with instructions to consider such statutory mandate that fee ceilings be based upon similar services. 728 F. 2d at 333. Rather than appeal on the merits, the government has seen fit to establish one fee ceiling for all physicians. See Attachment B. Furthermore, the suggestion that Petitioners continue to contest the decision of this case on the merits is in direct contravention of the testimony established in this case, that there was no meaningful difference between physicians of different specialties performing the same medical procedure.

SUMMARY OF ARGUMENT

This case presents the issue of whether the Department of Health and Human Services can develop a system of hearings and review that effectively preclude any possibility for the redress of substantial statutory and constitutional claims. The import of this Court's decisions in *Weinberger* v *Salfi*, 422 US 749 (1975); *United States* v *Erika, Inc.*, 456 US 201 (1982); *Heckler* v *Ringer*, ___ *US* ___; *104 S Ct 2013 (1984); and Schweiker* v *McClure*, 456 US 188 (1982) strongly indicate that the interpretation placed upon 42 USC Sec. 405(h) and Sec. 1395ff by the Petitioner is untenable.

The regulatory and administrative authority pertinent to this matter strip the administrative process of the ability to address the claims pressed by Respondents. The decisions of this Court have never concluded that the above statutory provisions preclude jurisdiction over substantial statutory or constitutional claims for which no other review is accorded. Rather, this court has in fact addressed substantial constitutional claims arising out of the Medicare Program in *Schweiker* v *McClure, supra*. This Court's decisions in *Salfi, Erika*, and *Ringer* stand for the proposition that claimants must pursue any available administrative remedy before asserting federal court jurisdiction and that federal court jurisdiction is precluded for "amount of benefit" cases.

This case cannot be characterized as an "amount of benefit" case which involves whether a particular claim is payable under the Medicare Program or the specific amount of payment. To the contrary, Respondents have never sought an increase in the level of payments or a specific amount of payment. Rather, Respondents, as in *McClure*, made a broad statutory and constitutional claim against the federal regulations. The claims made did not address the specific amount to be paid, but rather addressed a classification scheme inconsistent with a mandate of the Medicare statute. These claims were certainly not insubstantial.

The construction of Sec. 405(h) and 1395ff advanced by Petitioners would allow Petitioners to violate the applicable

statute and the United States Constitution with impunity. Indeed, in the district court Petitioners admitted a violation of the law, refused the district court's suggestion that a remedy be fashioned, but yet now insist that no forum exists for redress of the very violation they concede. It is respectfully suggested that this Court must interpret 42 USC Sec. 405(h) and 1395ff in such a fashion as to avoid a serious constitutional issue and in a fashion which also gives meaning and effect to the various provisions of the Act.

ARGUMENT

Through the last several years, this Court has had several occasions to consider the administrative review mechanisms of the Social Security Act and the related issue of federal court jurisdiction. See *Weinberger* v *Salfi*, 422 U.S. 749 (1975); *United States* v *Erika, Inc.*, 456 U.S. 201 (1982); *Heckler* v *Ringer*, ___ US ___; 104 S. Ct. 2013 (1984). In addition, this court has previously addressed, without any significant discussion of jurisdiction, a constitutional challenge to the administrative review mechanisms of Part B of the Medicare Program. *Schweiker* v *McClure*, 456 U.S. 188 (1982). Contrary to the Petitioners' suggestion, a review of these decisions indicates that this Court has never interpreted or applied the provisions of the Social Security Act as foreclosing all forums to redress substantial statutory or constitutional issues.

In *Weinberger* v *Salfi*, *supra* at 761, this Court faced a constitutional challenge to provisions of the Social Security Act and carefully reviewed each of the three sections contained within Sec. 405(h) and concluded that this section constitutes more than a requirement for exhaustion of administrative remedies. The court further rejected any narrow reading of the language "any claim arising under . . . the Social Security Act" since the statute provided "both the standing and substantive basis for the presentation of . . . constitutional contentions." Significant

in the *Salfi* decision is the distinction of the prior case of *Johnson* v *Robison*, 415 U.S. 361 (1974), the court noting that acceptance of the government's interpretation of the statute in *Robison* would have meant that no judicial consideration of a constitutional challenge could have taken place. The court stated:

> Not only would such a restriction have been extraordinary, such that 'clear and convincing' evidence would be required before we could ascribe such intent to Congress . . . but it would have raised a serious constitutional question of the validity of the statute so construed. 422 U.S. at 763 (citations omitted)

It is clear from reviewing the decision in *Salfi* that this Court was concerned that Sec. 405(h) not be interpreted to preclude constitutional challenges. This principle was neither ignored nor forgotten in the subsequent decisions of this Court.

In *United States* v *Erika*, *supra*, the court faced a review following administrative hearing by the carrier pursuant to 42 USC Sec. 1395u(b)(3). The substantive challenge boiled down to the carrier's determination to base the reasonable charge calculation and payment to *Erika* upon a price list utilized by the Respondent. There was no constitutional claim pressed. See *US* v *Erika*, *supra* at fn. 5.

This court's opinion in *Erika* dealt mainly with the correct interpretation to be given to Sec. 405(h) in conjunction with Sec. 1395ff. Because Sec. 1395ff failed to provide for a hearing by the Secretary (or judicial review thereafter) for "amount of benefit" cases under Part B, and because the legislative history revealed an intent to preclude federal court jurisdiction in such cases, the court determined that the administrative hearing afforded in *Erika* was appropriate and no further judicial review was permissible.

Contemporaneously with issuing the *Erika* opinion, this Court also handed down its opinion in *Schweiker* v

McClure, supra. The *McClure* case once again dealt with Part B of the Medicare Program but was distinct from *Erika* in that the challenge in *McClure* was directed at the hearing procedure mandated by 42 USC Sec. 1395u(b)(3) and implemented through regulation. The Court did not consider the basic jurisdictional issue, but went on to substantively address the constitutional claims and ruled that the carrier hearing, as mandated by the statute and implemented through regulations, passed constitutional muster.

Heckler v *Ringer, supra*, again focused upon judicial review of a Medicare case, although the decision was limited, in the main, to a discussion of judicial review of a Part A claim. *Heckler* v *Ringer, supra*, at n. 4. Respondents challenged an instruction by the Secretary which denied Medicare reimbursement for a particular surgical procedure. The precise issue faced by this Court was whether the Respondents could pursue their case in federal district court prior to their claims first channeled into the administrative process available under Part A and, in the case of claimant Ringer, before the surgery was actually performed.

In *Ringer*, this Court declined the invitation not to enforce the provisions of Sec. 405(h) to a Medicare claimant since to do otherwise would have opened the door and allowed a by-pass of the administrative remedy and judicial review provided by the act. This court noted:

> If we allow claimants in Ringer's position to challenge in federal court the Secretary's determination . . . that BCBR surgery is not a covered service, we would be inviting them to by-pass the exhaustion requirements of the Medicare Act by simply bringing declaratory judgment actions in federal court before they undergo the medical procedure in question. *Ringer, supra*, at 2025.

From these precedents, the Petitioners weave their argument for requesting relief from this Court. From the *Salfi* opinion they take the principle that Sec. 405(h) applies to any action "arising under" the Medicare Act. From the

Erika opinion they take the principle that all "amount of benefit" cases are barred from judicial review (broadening this concept to any challenge "affecting the amount of benefits", see Questions Presented in Petition and Statement of Case in Petition).

From the *Ringer* opinion, Petitioners take the principle that administrative channels and judicial review established by Sec. 405(g) and Sec. 405(h) cannot be circumvented by a premature district court action by clothing benefit cases in procedural dress. Petitioners then characterize the present case as "affecting the amount of benefits" which "arises under" the Medicare statute and hence without federal court jurisdiction pursuant to Sec. 405(h). Despite the Petitioners' best efforts these cases cannot establish the principle that judicial review is foreclosed in a Part B Medicare case in which a statutory and constitutional challenge is made and for which there is no administrative process to address these challenges. Indeed, the decisions of this Court stand for quite the opposite.

The court's analysis of *Salfi* recognizes that the challenges made by the claimants could be properly addressed and channeled through the administrative process provided by Sec. 405(g). In *Erika* judicial review was foreclosed but only over certain types of challenges, namely amount of benefit cases, since there was clear legislative intent to free the judicial process of these small benefit cases. This Court recognized that the constitutional claims presented were neither pressed before this court nor of a substantial nature. In *Erika* a judicial forum was not available since such a forum was not expressly provided by statute and legislative history revealed an intent to bar judicial review of the very type of claim being pressed. Petitioners' attempt to broaden the holding in *Erika* to any case "affecting the amount of benefits" is in substantial contrast to the legislative history this Court relied upon in support of its decision that there was no federal court jurisdiction in amount of benefit cases. In that case, the Court quoted the Senate report on the original

Medicare Act, which stated that the Act did not provide for judicial review of "a determination concerning the amount of benefits under Part B" and that the provision for review by carriers under Part B was intended as the "exclusive" remedy. See *Erika*, *supra* at 208, 209. Quoting S. Rep. 404, 89 Cong. 1st Sess. 44-45 (1965). The court also noted the conference report on the 1972 Amendments, 42 USC 1395ff, which explained that "there is no authorization . . . for judicial review on matters *solely* involving amount of benefits under Part B" (456 US at 210, quoting H. R. Conf. Rep. 92-1605, 92nd Cong. 2d Sess. 51 (1972). (Emphasis added.)

The present case was initiated as a statutory and constitutional challenge to regulation promulgated by the Secretary. Respondents were not seeking any specific payment level concerning a particular medical service (contrast both *Erika* and *Ringer*) but were claiming that the Secretary and the Carrier had gone beyond the basic mandate of both the Medicare Act and the United States Constitution. Like *McClure*, Respondents made a broad challenge to the promulgation of a regulation. That challenge was not based upon a question of medical necessity or proper application of the Medicare regulations to a particular claim for payment. Unlike the challenge asserted by Respondents, such claims could have been pursued through the administrative hearing mechanism mandated by 42 USC 1395u(b)(3) and established by regulation.

Respondents' claims were based on the premise that whatever payments are to be made should be made according to "similar service" and the regulation in issue violated this statutory requirement. Respondents objected not to the application of the classification scheme set forth in the regulation, but rather the classification scheme itself. In an attempt to equate Respondents' claim to that of the Respondents in *Erika*, the Petitioners makes note of the fact that the Court of Appeals acknowledged that the eventual result of this suit may cause an increase in amounts of reimbursement for services to family physicians. See Petition at p. 6.

The actual quote from the Court of Appeals provides a much more thorough and accurate analysis:

> In this case BC/BSM contends this suit involves simply a dispute over the amount of reimbursement due. In a word, BC/BSM contends, Michigan Academy is simply seeking to have family physicians and their patients moved to the more lucrative specialty screen, boiling down to an argument for an increase in amounts reimbursed. *Erika*, it concludes, should bar this suit outright. This argument, however, is without merit.
>
> While the eventual result of this suit may cause an increase in amounts of reimbursement, that does not necessarily follow. In some cases the result may be an increased amount of reimbursement, and in others, a reduction in reimbursement could occur. Michigan Academy, at bottom line, is challenging the overall mechanism for determining the amounts of reimbursements, not the actual value of any particular reimbursement.
> 728 F. 2d at 330.

Accordingly, it is inaccurate to characterize Respondents' case as simply seeking to increase the "amount of benefits" they may receive under the Medicare Program. The reasonable charge calculation under the Medicare Program requires a grouping of all similar services to establish a ceiling at that figure which would pay seventy-five percent of all claims submitted. See 42 USC Sec. 1395u(b)(3). Respondents sought the elimination of specialty screens, not the transfer of individual claims from the "generalist screen" to the "specialist screen." Such a remedy would be totally contrary to the crux of Respondents' claim that the maintenance of different screens among physicians for the same service violated the Medicare statute and the United States Constitution. Respondents' claims were delineated to address the groupings or classification scheme itself and the illegal and unconstitutional aspects of the disputed regula-

tion. Since the thrust of Respondents' Complaint related to those groupings, a payment dispute on an individual claim could not afford the relief requested. Rather, the overall grouping mechanism had to be reviewed in the context of Petitioners' statutory authority for its actions.

Perhaps nothing belies the Petitioners' attempt to pigeon-hole Respondents' challenges as "amount of benefits claims" more clearly than Petitioners' own implementation of 42 USC 1395u(b)(3), the statutory authority for carrier hearings on amount of benefit cases. As noted, Petitioners specifically removed from the carrier's power the authority to address the very type of challenge being pursued by Respondents. Undaunted, Respondents now attempt to pigeon-hole Respondents' challenges as "amount of benefit" claims while denying a forum for review.

A review of the statutory and regulatory scheme here certainly does not reveal "a fairly discernible intent" to preclude judicial review for a Part B case which raises substantial statutory and constitutional issues. The impact of Sec. 1395ff in conjunction with Sec. 1395u(b)(3) and Sec. 405(h) evidences a legislative intent to channel small amount of benefit cases through an administrative hearing process conducted not by the Secretary but by the carrier.

What is discernible in this scheme is only the foreclosure of judicial review of those issues for which an administrative hearing is available. The legislative history discussed in *Erika* obviously cannot be read as evidencing an intent to foreclose judicial review for claims of a type other than the amount of benefit claims discussed in that history.

In fact, the essence of the Petitioner's legal posture is that an agency of the federal government may violate the Medicare statute or the Fifth Amendment of the United States Constitution with no forum for those affected to take redress. The complete absence of judicial oversight over the entire regulatory program would raise a serious constitu-

tional issue concerning the improper delegation of legislative power to the executive. See *Amalgamated Meat Cutters* v *Connally*, 337 F. Supp. 737, 759 (DCDC 1971) and *Yakus* v *United States*, 331 U.S. 414, 423-426 (1944). The denial of a forum for addressing constitutional rights is a question of exceptional importance and significance, and is tantamount to overruling *Marbury* v *Madison*, 1 Cranch 137, 2 L. Ed. 60 (1803). It is a matter of law and precedent with this Court that the foreclosure of all forums to address substantial constitutional claims itself raises "serious constitutional questions." See *Johnson* v *Robison*, *supra*, and *Bob Jones University* v *Simons*, 416 U.S. 725 (1974). This Court has called it a "cardinal principle" that statutory provisions are to be interpreted so as to avoid this very sort of basic constitutional question. See *United States* v *Thirty Seven (37) Photographs*, 402 U.S. 363 (1971); *Johnson* v *Robison*, *supra*, and *Crowell* v *Benson*, 285 U.S. 22 (1932).

The Petitioners characterize the Sixth Circuit's decision as a disregard of this Court's clear pronouncement and perhaps encouraging anarchy. See Petition, pp. 11, 22. One would at least expect that such strong language be accompanied with a clear statement of Petitioners' position. Unfortunately, the Petitioners have thoroughly ignored the basic fact that a denial of federal court jurisdiction in this case would preclude any forum to address the statutory and constitutional challenges of Respondents and would create an extraordinary constitutional issue in itself. Petitioners simply have not demonstrated a basis for granting of this Writ of Certiorari.

CONCLUSION

The Petition for Writ of Certiorari should be denied.

Respectfully submitted,

FRIMET, BELLAMY & GILCHRIST, P.C.
By: ALAN G. GILCHRIST
Counsel of Record

ATTACHMENT A

TRIAL TRANSCRIPT

* * * trial.

Q. Have you ever heard of any rationale with then HHS as to why the carrier in Michigan has treated board eligible family physicians different from other types of board eligible physicians?

A. I have never seen anything that fully explains that. I have been under the impression at one time or another that there were differences in the various board rules dealing with the requirements of becoming board certified that the carrier was concerned about, but I do not recall what they are specifically.

MS. MAYES: Your Honor, if I might just raise a question. We have indicated at the beginning of this case that we believe that we were incorrect in defining family practioners, that is, those who were board eligible, as not being specialists, and that therefore we conceded that fact before this trial ever began. That was an incorrect application of that board eligible definition, so that board eligible family practioners should be defined as specialists by the carrier in the State of Michigan.

THE COURT: And should be put in the screen?

MS. MAYES: That question is what is left open, but the definition of what we called them was (64) incorrect.

THE COURT: All right. Go ahead.

BY MR. GILCHRIST:

Q. Would it be a fair statement that the rationale that you have heard for treating board eligible family physicians differently from other board eligible physicians has never been related to any charging patterns?

A. I am not sure I understand your question. I am sorry.

Q. Well, you said you talked about—there was something about qualifications of speciality boards as one of the rationale.

ATTACHMENT B

[LETTERHEAD OF BLUE CROSS/BLUE SHIELD]

August 27, 1984

C. Edward Cotton, M.D.
President
Michigan Academy of Family Physicians
109 East Oakland
Lansing, Michigan 48906

Dear Doctor Cotton:

Attached for your information is an announcement on BCBSM Regular Business/Medicare comparability. As a result of instructions from the Health Care Financing Administration (HCFA), BCBSM will apply corresponding Regular Business screens as comparability limits on Medicare prevailing screens. The attached explains the details of the HCFA directive.

Although this information will appear in a future Record article, I wanted to share this with you as soon as possible.

Sincerely,

(s) Robert H. Hamburg, M.D.
Senior Liaison Consultant
Medical Affairs

RHH:svc
Attachment

REGULAR BUSINESS PROGRAM SCREEN COMPARABILITY AND COURT DECISION APPLY TO MEDICARE SCREEN FREEZE

The Deficit Reduction Act of 1984 (DRA 1984) has put a freeze on physician payment levels from July 1, 1984 through September 30, 1985, or 15 months. At the same time, the Health Care Financing Administration (HCFA) has instructed BCBSM that Comparability (Section 1842(b)(3) of the Medicare law) applies to the frozen screen levels. For regulations concerning Comparability, see Section 42 CFR 405.508. Therefore, BCBSM will apply the corresponding regular business screens as Comparability limits on Medicare prevailing screens.

The regular business screens were established based on a relative value scale. A relative value scale ranks procedures by comparison of the complexity, skill, time and resources required for each procedure. Procedures that are more complex and/or require more skill, time or resources are ranked higher than those that require less. In the past, regular business screens were determined primarily based on charges billed to BCBSM. Because charges do not always reflect complexity, skill, time and resources of one procedure in relation to another; screens for many procedures were too low, while screens for other procedures were too high. To correct the imbalance, the relative value relationship methodology for establishment of maximum screens was approved by the BCBSM Board of Directors in 1983, and is currently used for regular business screen determination.

In addition, BCBSM was instructed by HCFA to implement a decision handed down by the United States Court of Appeals for the Sixth Circuit. The court decision requires BCBSM to merge charge data for all physicians, including chiropractors, dentists, podiatrists, and optometrists in calculating a new prevailing charge screen. BCBSM will apply this calculation to the frozen fee screens. As a result, physicians may experience changes in payment for selected services.

Supreme Court, U.S.
FILED
SEP 26 1985
JOSEPH F. SPANIOL, JR.
CLERK

(3)

No. 85-225

In the Supreme Court of the United States

OCTOBER TERM, 1985

MARGARET M. HECKLER, SECRETARY OF HEALTH AND HUMAN SERVICES, ET AL., PETITIONERS

v.

MICHIGAN ACADEMY OF FAMILY PHYSICIANS, ET AL.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

REPLY BRIEF FOR THE PETITIONERS

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The court of appeals held in this case that the district court could entertain respondents' challenge to a regulation that affects the amount payable on a claim for benefits under the Part B Medicare Program. We have demonstrated in the certiorari petition that this holding is flatly inconsistent with the statutory preclusions of review applicable to the Part B Medicare Program (42 U.S.C. 1395ff, 405(h)) and with the decisions of this Court in *Weinberger* v. *Salfi*, 422 U.S. 749 (1975); *United States* v. *Erika, Inc.*, 456 U.S. 201 (1982); and *Heckler* v. *Ringer*, No. 82-1772 (May 14, 1984). See Pet. 11-20.

We also have explained that the decision below directly conflicts with the Fourth Circuit's decision in *Starnes* v. *Schweiker*, 748 F.2d 217 (1984), cert. denied, No. 84-1309 (Apr. 15, 1985), concerning the interpretation of 42 U.S.C. 1395ff (see Pet. 20-21), and with decisions of other courts of

appeals since *Ringer* that have construed 42 U.S.C. 405(h) to preclude judicial review pursuant to 28 U.S.C. 1331 even of "procedural" challenges arising under the Social Security Act (see Pet. 21).[1] In addition, the Eighth Circuit has recently held that Section 405(h) bars a district court from entertaining a procedural challenge arising under the Part B Medicare Program. See *Hatcher* v. *Heckler*, No. 84-5170 (Sept. 4, 1985).

Respondents do not dispute that the decision below conflicts with these decisions of other courts of appeals. Nor do they explain why that conflict does not warrant resolution by this Court. Respondents instead devote their brief in opposition to a reargument of several positions that were rejected by the Court in *Salfi*, *Erika*, and *Ringer*. None of these points has merit.

1. a. Respondents insist (Br. in Opp. 15-18) that the court of appeals' decision is not inconsistent with *Erika* because that case held only that judicial review of decisions concerning the amount of benefits under Part B is foreclosed by 42 U.S.C. 1395ff; in respondents' view, this case involves a challenge not to the amount of benefits paid on a Part B claim, but rather to the separate grouping of certain family physicians and other categories of persons who furnish Part B services. This attempt to distinguish *Erika* is unavailing.

As respondents concede (Br. in Opp. 13), *Erika* concerned a challenge to the carrier's calculation of the "reasonable charge" under Part B for particular medical services. Under 42 U.S.C. 1395u(b)(3), in determining the "reasonable charge" for such services, the carrier is to take into

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[1]See *American Federation of Home Health Agencies, Inc.* v. *Heckler*, 754 F.2d 896, 897-898 (11th Cir. 1984); *Ganem* v. *Heckler*, 746 F.2d 844, 848 (D.C. Cir. 1984); *Smith* v. *North Louisiana Medical Review Ass'n*, 735 F.2d 168, 171-172 (5th Cir. 1984).

account both the "customary charge" made by the physician and the "prevailing charge" in the area. The "prevailing charge" is to be calculated at a rate that would cover 75% of the customary charges made for "similar services" in the locality. In *Erika*, the plaintiff challenged the carrier's decision to calculate the "prevailing charge" on the basis of prices charged in the preceding calendar year, without taking into account intervening price increases. The plaintiff contended that this method of calculating the prevailing charge, which had the effect of imposing a ceiling on the amount of benefits paid by the carrier, violated the Social Security Act and implementing regulations. See 456 U.S. at 204-205 & n. 2. This Court, however, unanimously held that judicial review was precluded. *Id.* at 206-211.

Respondents' challenge is legally indistinguishable from that in *Erika*. Like the plaintiff in *Erika*, respondents challenge the carrier's calculation of the prevailing charge. The only difference is that respondents take issue with the carrier's identification of what are "similar services" for purposes of calculating that charge, while in *Erika* the challenge was to the year in which the similar services were rendered. This difference has no bearing on the availability of judicial review. In either case, the challenge is to the carrier's methodology in calculating the prevailing charge component of the "reasonable charge" for particular Part B services, which in turn determines the amount of benefits the carrier will pay for those services. *Erika* therefore squarely controls this case.

b. Respondents also argue (Br. in Opp. 11, 12, 15, 16, 17) that neither 42 U.S.C. 1395ff nor 42 U.S.C. 405(h) should be construed to preclude judicial review of what they term "statutory" issues that may arise in connection with the carrier's determination and payment of benefits. In this case, for example, respondents contend that the carrier's grouping of services in separate charge screens, depending

on whether they were performed by certain specialists or others, is inconsistent with the statutory provision in 42 U.S.C. 1395u(b)(3) that the carrier take into account the prevailing charge for "similar services."[2] However, respondents' assertion that 42 U.S.C. 1395ff does not bar such "statutory" challenges is foreclosed by *Erika* and *Ringer*. As noted above, the plaintiff in *Erika* contended that the carrier's formulation of the prevailing charge screen was contrary to the Social Security Act (456 U.S. at 205), but this Court nevertheless held that judicial review was foreclosed. Similarly, the plaintiffs in *Ringer* contended that the Secretary's instructions that required the carriers to refuse to pay any amount of benefits for BCBR surgery violated the Social Security Act and the Administrative Procedure Act (see *Ringer*, slip op. 7 & n.7), but this Court nevertheless held that judicial review was foreclosed under 42 U.S.C. 1395ff and *Erika* insofar as the case concerned the Part B Program (*Ringer*, slip op. 5 n.4).[3]

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[2]As we explained in the first certiorari petition in this case (84-120 Pet. 12 n.5), common sense suggests that there is a difference in the nature of services depending on whether they are furnished by a specialist or a generalist, because the former presumably brings greater expertise or experience to bear. At the very least that is a permissible interpretation of the term "similar services" in the Act, especially in view of the fact that the regulation authorizing the carrier to develop different charge screens on such a basis was promulgated in 1967, only one year after the Medicare Program went into effect. That contemporaneous and longstanding administrative interpretation accordingly should be binding on the courts (and therefore on respondents) even if, contrary to our submission in the text, judicial review were not entirely foreclosed in this case. *Chevron U.S.A. Inc.* v. *NRDC*, No. 82-1005 (June 25, 1984), slip op. 5.

[3]Respondents also contend that the preclusion of review under 42 U.S.C. 1395ff applies only to those issues that can be raised and decided in an evidentiary hearing before the carrier, such as the application of the Act, regulations and instructions to a particular claim and the arithmetic computation of the amount due on that claim. On this premise, respondents argue that because governing regulations (42

In any event, even if 42 U.S.C. 1395ff did not foreclose judicial review of respondents' statutory objections, review nonetheless would be foreclosed by 42 U.S.C. 405(h). The third sentence of Section 405(h) provides that "[n]o action against the * * * Secretary * * * shall be brought under section[] 1331 * * * of title 28 to recover on any claim arising under this subchapter." The Court held in *Ringer* that this provision bars a district court from exercising federal question jurisdiction over a statutory challenge to the "procedures" utilized by the Secretary for determining the amount of benefits due under Medicare. Slip op. 10-13.

2. Respondents also repeatedly assert (Br. in Opp. 11-19) that this case presents a question concerning the preclusion of judicial review of constitutional questions. Again, respondents are mistaken. The district court and court of appeals expressly did not reach the question whether the differing charge screens formulated by the carrier under the authority of the Secretary's regulation deprived family physicians of equal protection and due process. See Pet. App. 5a, 13a n.5, 27a-28a, 32a. If this Court reverses the judgment below finding jurisdiction over respondents' statutory challenge, the Court could remand to the court of appeals to consider whether the district court had jurisdiction over respondents' constitutional challenge and, if so, to decide the merits of

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C.F.R. 405.860) and the Carrier's Manual state that the carrier's hearing officer is bound by the Act and implementing regulations and instructions issued by the Secretary, *judicial* review of such issues is not foreclosed. See Br. in Opp. 3-4, 15, 16, 18. That is precisely the argument that was made by the American Academy of Family Physicians in *Erika* itself (80-1594 Amicus Br. at 11-18, 31), but it was not accepted by this Court. Similarly, in *Ringer*, the reimbursement claims under Part B were denied by the carrier on the basis of binding instructions that withdrew from the carrier hearing officer the question whether BCBR was a reasonable and necessary procedure covered by Medicare (slip op. 3-4), but the Court held that judicial review was barred under *Erika* (*Ringer*, slip op. 5 n.4).

that question. However, we do not believe that it is necessary for the Court to remand for still further proceedings in this case, which was filed almost nine years ago.

In *Schweiker* v. *McClure*, 456 U.S. 188 (1982), this Court, without addressing the question of the district court's jurisdiction, reviewed the merits of a constitutional challenge to certain provisions of the Medicare title of the Social Security Act. We may assume for present purposes that the Court in *McClure* believed that 42 U.S.C. 1395ff and 405(h) should not be construed to foreclose a judicial challenge to the constitutionality of provisions of the Social Security Act itself. Cf. *Hatcher* v. *Heckler*, slip op. 9 n.7. Compare *Salfi*, 422 U.S. at 762; *Johnson* v. *Robison*, 415 U.S. 361, 366-367 (1974). In this case, however, respondents do not challenge the constitutionality of any provision of the Social Security Act. They challenge only the constitutionality of one carrier's method of calculating the reasonable charge for particular services, in conformity with a regulation issued by the Secretary. *McClure*, *Salfi*, and *Johnson* do not indicate that it might be unconstitutional for Congress to foreclose judicial review of constitutional issues that arise in connection with such administrative determinations made under a program established by an Act of Congress.

There is no need to resolve that question in this case, however, because here, as in *Ringer* (slip op. 5 n.4), respondents' constitutional contention is too insubstantial to support subject matter jurisdiction in any event. The regulation respondents challenge simply recognizes the obvious practical reality that "[t]he range of prevailing charges in a locality may be different for physicians * * * who engage in a specialty practice or service than for others," and it accordingly permits a carrier to develop more than one range of prevailing charges that reflect

"[e]xisting differentials in the level of charges between different kinds of practice or service" (42 C.F.R. 405.504(b)). That clearly is not an irrational approach to determining the amount of payments to be made under the Medicare Program. The medical profession itself, through the system of board certification and in other ways, draws distinctions on the basis of a physician's specialization. The Constitution surely does not prohibit the Secretary from giving effect to those distinctions in making payments for services rendered by such physicians under this vast and complex social welfare program.

For the foregoing reasons and the additional reasons stated in the petition, it is respectfully submitted that the petition for a writ of certiorari should be granted, the judgment of the court of appeals should be summarily reversed, and the case should be remanded with instructions to dismiss the complaint.

CHARLES FRIED
Acting Solicitor General

SEPTEMBER 1985

Supreme Court, U.S.
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CLERK

No. 85-225

In the Supreme Court of the United States

OCTOBER TERM, 1985

MARGARET M. HECKLER, SECRETARY OF HEALTH AND HUMAN SERVICES, ET AL., PETITIONERS

v.

MICHIGAN ACADEMY OF FAMILY PHYSICIANS, ET AL.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

BRIEF FOR THE PETITIONERS

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QUESTION PRESENTED

Whether, notwithstanding the preclusions of review in 42 U.S.C. 1395ff and 405(h), the district court properly exercised jurisdiction under 28 U.S.C. 1331 to entertain respondents' challenge to a regulation affecting the carrier's calculation of the amount of benefits payable for certain physicians' services under Part B of the Medicare Program.

PARTIES TO THE PROCEEDING

The petitioners are Margaret M. Heckler, Secretary of Health and Human Services, and Blue Cross and Blue Shield of Michigan, an insurance carrier that has contracted with the Secretary pursuant to 42 U.S.C. 1395u to administer the Part B Medicare Program in Michigan on her behalf.

The respondents are: (1) the Michigan Academy of Family Physicians, a non-profit association of family physicians in Michigan; (2) Lester Webb and Charles Farber, family physicians who are eligible for specialist certification under the standards of the American Board of Family Practice but who have not been certified as specialists under those standards; (3) Glenn House, a family physician certified as a specialist under the standards of the American Board of Family Practice; and (4) Carol A. Diedrich, a resident of Michigan and a Medicare Part B recipient whose treating physician, Philip Lange, is a family physician who is neither Board-certified nor Board-eligible.

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ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

BRIEF FOR THE PETITIONERS

OPINIONS BELOW

The original opinion of the court of appeals (Pet. App. 1a-15a) is reported at 728 F.2d 326. The November 5, 1984 order of the court of appeals (Pet. App. 16a), following the remand by this Court (No. 84-120 (Oct. 1, 1984)), is reported at 751 F.2d 809. The March 19, 1985 opinion of the court of appeals (Pet. App. 17a-22a), rendered on respondents' petition for rehearing, is reported at 757 F.2d 91. The opinion of the district court (Pet. App. 23a-33a) is reported at 502 F. Supp. 751. The earlier memorandum opinion of the district court (J.A. 10-12) denying the Secretary's motion to dismiss the complaint for lack of jurisdiction is unreported.

JURISDICTION

The judgment of the court of appeals was entered on March 19, 1985. The Secretary's petition for rehearing was denied on May 30, 1985 (Pet. App. 35a). The petition for a writ of certiorari was filed on August 9, 1985, and was granted on October 7, 1985 (J.A. 63). The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATUTORY PROVISIONS AND REGULATION INVOLVED

28 U.S.C. 1331; relevant provisions of Sections 205(h), 1842 and 1869 of the Social Security Act, 42 U.S.C. 405(h), 1395u and 1395ff; and 42 C.F.R. 405.504(b) are reproduced at App., *infra*, 1a-6a.

STATEMENT

The question presented in this case is whether the district court had jurisdiction under 28 U.S.C. 1331 to entertain a challenge to a regulation promulgated by the Secretary of Health and Human Services that affects the amount of benefits for certain physicians' services under Part B of the Medicare Program.

A. The Statutory Framework

The Medicare Program is divided into two parts. Part A provides insurance for hospital and related post-hospital services. 42 U.S.C. 1395c, 1395d. Part B establishes a voluntary program of supplementary medical insurance covering, in general, 80% of the "reasonable charge" for physicians' and other medical services. 42 U.S.C. 1395k, 1395*l*, 1395x(s).

1. *Procedural Provisions*

a. Part A of the Medicare Program authorizes the Secretary to enter into contracts with fiscal intermediaries under which the intermediaries deter-

mine whether particular services are covered by Part A and, if so, the amount of benefits that are payable. 42 U.S.C. 1395h. See *Heckler* v. *Ringer*, No. 82-1772 (May 14, 1984), slip op. 2-3. If the intermediary determines that a particular service is not covered by Part A or that the amount of benefits is less than the full cost to the beneficiary, the claimant is entitled to seek reconsideration by the Health Care Financing Administration (HCFA) in the Department of Health and Human Services (HHS). 42 C.F.R. 405.710-405.716. If the intermediary's denial of the claim is affirmed on reconsideration and the amount in controversy is at least $100, the claimant has a statutory right to an evidentiary hearing before an administrative law judge (ALJ) in HHS to the same extent as is provided in 42 U.S.C. 405(b). 42 U.S.C. 1395ff(b)(1)(C) and (2). If the ALJ denies the claim and the Appeals Council sustains that decision, and if the amount in controversy is $1,000 or more, the claimant may seek judicial review to the same extent as is provided in 42 U.S.C. 405(g). 42 U.S.C. 1395ff(b)(1)(C) and (2). See *Ringer*, slip op. 3. On judicial review, the court may consider the validity of any law, regulation or ruling that had the effect of limiting or denying Part A benefits to the claimant. See *Ringer*, slip op. 10-11, 13.

The Medicare Act also provides a mechanism for a hospital or other provider of Part A services to obtain review of the amount it will be reimbursed. A provider is paid an aggregate amount for all Part A services rendered during the relevant time period. See *Heckler* v. *Community Health Services*, No. 83-56 (May 21, 1984), slip op. 2.[1] If the provider is dis-

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[1] The calculation of payments under Part A has been revised by Section 1886 of the Act, 42 U.S.C. (& Supp. I)

satisfied with the intermediary's determination, and if the amount in controversy is $10,000 or more, the provider may request a hearing before the Provider Reimbursement Review Board (PRRB) in HHS. 42 U.S.C. 1395*oo*(a) and (c). The provider then may seek judicial review in district court of an adverse "final decision" of the PRRB. 42 U.S.C. 1395*oo* (f)(1); *Heckler* v. *Community Health Services*, slip op. 6. On judicial review of the PRRB's final decision, the court may consider the validity of any law, regulation, or ruling that had the effect of limiting the amount of reimbursement. In addition, the Act allows a provider to obtain expedited judicial review, without awaiting the PRRB's final decision, of any "question of law or regulations relevant to the matters in controversy whenever the [PRRB] determines * * * that it is without authority to decide the question" (42 U.S.C. 1395*oo*(f)(1); see 42 C.F.R. 405.1842).

b. Congress has provided for far more limited review of benefit determinations under the Part B Medicare Program, at issue here. The Secretary is authorized to enter into contracts with private insurance carriers under which the carriers determine whether particular services are covered by Part B and the amount of the "reasonable charge" for those

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1395ww. That Section institutes a prospective payment system under which providers are reimbursed at a flat rate for each service. See *Heckler* v. *Redbud Hospital Dist.*, No. A-32 (July 24, 1985), slip op. 1-2 (Rehnquist, Circuit Justice). Under the new payment system, the rights of beneficiaries and providers to administrative and judicial review still are governed by 42 U.S.C. 1395ff and 1395*oo*, although Congress has restricted a provider's right of review in several respects. See 42 U.S.C. (Supp. I) 1395ww(d)(7)(B), 1395*oo*(g)(2), discussed at pages 27-28, *infra*.

services. 42 U.S.C. 1395u; 42 C.F.R. 405.803-405.806. See *Schweiker* v. *McClure*, 456 U.S. 188, 190 (1982). If the carrier determines that the services are not covered by Part B or that the payment due is less than the amount claimed, the claimant is entitled to a review determination by the carrier. 42 C.F.R. 405.807-405.811. See *United States* v. *Erika, Inc.*, 456 U.S. 201, 203 (1982); *McClure*, 456 U.S. at 191. If the decision after the review determination is adverse to the claimant and the amount remaining in controversy is $100 or more, the claimant is entitled by statute to an evidentiary hearing by the carrier. 42 U.S.C. 1395u(b)(3)(C); 42 C.F.R. 405.812-405.835. See *McClure*, 456 U.S. at 191.

In contrast to the Part A Program, there is no provision under Part B for administrative review by HHS of the carrier's denial of a claim. 42 C.F.R. 405.502(d). Moreover, although 42 U.S.C. 1395ff (b)(1)(C) expressly provides for the claimant to obtain judicial review of the "amount of benefits" payable under Part A, there is no parallel provision in 42 U.S.C. 1395ff for a claimant to obtain judicial review of the "amount of benefits" payable under Part B. In *Erika*, the Court held that by this omission, Congress "deliberately intended to foreclose further review of such claims" (456 U.S. at 208). Accord *Ringer*, slip op. 5 n.4.

The Act likewise does not contain any special procedures under Part B, similar to those available to Part A providers under 42 U.S.C. 1395*oo*, for a physician to obtain administrative or judicial review of the carrier's determination regarding the amount of benefits payable for covered services. This is because under Part B, benefits are paid to the beneficiary,

not the physician, unless the beneficiary assigns his reimbursement claim to the physician. 42 U.S.C. 1395u(b)(3)(B)(i) and (ii). In the latter event, the physician stands in the shoes of the beneficiary and has the same right to an evidentiary hearing by the carrier. 42 C.F.R. 405.801(a); *Erika*, 456 U.S. at 203, 207 n.7. But as the Court held in *Erika*, Congress also has foreclosed the assignee of a Part B claim from obtaining judicial review.

2. *Substantive Provisions*

a. The Social Security Act requires a carrier that administers the Part B Program to make payment for covered services on the basis of the "reasonable charge" for the services. 42 U.S.C. 1395u(b)(3)(B). In determining the reasonable charge, the carrier must "take[] into consideration the customary charges for similar services generally made by the physician * * * as well as the prevailing charges in the locality for similar services." 42 U.S.C. 1395u(b)(3). Congress amended 42 U.S.C. 1395u(b)(3) in 1972 specifically to provide that "[n]o charge may be determined to be reasonable * * * if it exceeds * * * the prevailing charge level that, on the basis of statistical data and methodology acceptable to the Secretary, would cover 75 percent of the customary charges made for similar services in the same locality during the last preceding calendar year * * *." Pub. L. No. 92-603, § 224(a), 86 Stat. 1395. Applying these principles, the "reasonable charge" for a physician's services ordinarily is the lowest of: (1) the actual charge in the particular instance, (2) the individual physician's customary charge, and (3) the prevailing charge in the locality for similar services (Pet. App. 2a-3a). See 42 C.F.R. 405.502.

b. The regulation respondents challenge in this case was promulgated in August 1967 (32 Fed. Reg. 12601), just one year after the Medicare Program went into effect (see 42 U.S.C. 1395q(a)(1)). It was intended to furnish the carriers guidance in giving content to the "prevailing charge" component of the "reasonable charge" calculation. The regulation recognizes that "[t]he range of prevailing charges in a locality may be different for physicians * * * who engage in a specialty practice or service than for others." 42 C.F.R. 405.504(b). It further permits (but does not require) a carrier, based on "[e]xisting differentials in the level of charges between different kinds of practice or service," to develop "more than one range of prevailing charges for application by the carrier in its determinations of reasonable charges." *Ibid.* The regulation stresses, however, that "[c]arrier decisions in this respect should be responsive to the existing patterns of charges by physicians and other persons who render covered services, and should establish differentials in the levels of charges between different kinds of practice or service only where in accord with such patterns." *Ibid.*

Consistent with this regulation, Blue Cross/Blue Shield of Michigan (BC/BSM), the carrier responsible for administering the Part B Program in Michigan, conducted a statistical analysis of differentials in physicians' charges in that State in 1968. Based on its analysis, BC/BSM identified three categories of physicians for reimbursement purposes: (1) hospital internists and other hospital specialists, (2) other specialists, and (3) general practitioners and other non-specialists. The prevailing charges for specialists in Michigan generally were higher than those

for non-specialists, and a Part B beneficiary therefore ordinarily received a greater dollar amount in reimbursement for the greater expense he incurred in being treated by a specialist. Pet. App. 4a. Following creation of the family practice specialty, BC/BSM in 1973 classified Board-certified family practitioners in the specialist category, but family physicians who were merely eligible for Board certification and family physicians who were neither Board-eligible nor Board-certified were grouped with the non-specialists. *Ibid.*[2]

B. The Proceedings In This Case

1. a. Respondents filed this action on October 8, 1976 in the United States District Court for the Eastern District of Michigan to challenge BC/BSM's classification of family practitioners for purposes of calculating the prevailing charge level for their services (J.A. 1; C.A. App. 11-29). The initial plaintiffs were the Michigan Academy of Family Physicians, one Board-certified family practitioner, and two Board-eligible family practitioners (C.A. App. 11-12, 19, 19-20). Later, a Part B beneficiary who was the patient of a family practitioner who was neither Board-certified nor Board-eligible was joined as a plaintiff (Pet. App. 31a-32a; J.A. 57-59). In their amended complaint (J.A. 14-30), respondents alleged that the differing treatment of family physicians (i) was inconsistent with the requirement in 42 U.S.C. 1395u(b)(3) that the reasonable charge be calculated by reference to the prevailing charge for "similar services," and (ii) violated the prohibition in 42

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[2] The government acknowledged in district court that, under standards in effect at the time of trial, Board-eligible family physicians also should be included in the specialist category (Pet. App. 27a).

U.S.C. 1395a against interference by the Secretary with a beneficiary's selection of a physician (J.A. 26-27). Respondents further alleged that BC/BSM and the Secretary had failed to produce adequate statistical data to support the maintenance of separate charge screens (J.A. 27).[3]

b. On December 28, 1977, the district court denied the motion of the Secretary and BC/BSM to dismiss the complaint for lack of jurisdiction (J.A. 10-12). The district court conceded that in challenging BC/BSM's charge screens, respondents "[w]ithout doubt * * * are motivated in part by a desire for increased payment for services" (J.A. 11). But the court nonetheless held that it had jurisdiction because an invalidation of BC/BSM's charge screens would not necessarily lead to an increase in any particular payments (J.A. 11).

c. On the merits, the district court held in an opinion dated December 30, 1980 that the establishment of separate charge screens is inconsistent with the Medicare Act and that 42 C.F.R. 405.504(b) is invalid to the extent it authorized the screens established by BC/BSM (Pet. App. 23a-33a). The court relied on 42 U.S.C. 1395u(b)(3), which requires the carrier to take into consideration and establish a ceiling based on the prevailing charge level for "similar services" in the locality. In the court's view, the

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[3] Respondents also alleged that the differing treatment of family physicians violated their Fifth Amendment rights to equal protection and substantive due process (J.A. 22-24) and violated their Fifth Amendment right to procedural due process by creating an irrebuttable presumption that their services were worth less than those of other physicians (J.A. 24-26). The district court and court of appeals did not reach these constitutional questions. Pet. App. 5a, 13a n.5, 22a-28a, 32a.

quoted term requires that services performed by physicians with different degrees of specialization be reimbursed at an identical level. Pet. App. 5a, 28a-30a. The court also held that the separate charge screens violate 42 U.S.C. 1395a because they "tend[] to influence the patient's choice of a physician" (Pet. App. 30a-31a). Finally, the court believed that BC/BSM did not identify an adequate factual or statistical basis for distinguishing among groups of physicians (*id.* at 28a, 31a).

2. In an opinion dated February 23, 1984, the court of appeals affirmed the district court's rulings on jurisdiction and the merits (Pet. App. 1a-15a).

a. The court of appeals conceded that 42 U.S.C. 1395ff and this Court's decision in *Erika* foreclose judicial review of the amount of benefits payable for particular services under Part B of the Medicare Program (Pet. App. 6a-8a), because "Congress clearly and convincingly intended that no judicial review of such questions was permissible" (*id.* at 7a). But the court observed that in the wake of *Erika*, several lower courts had "strenuously endeavored to find jurisdiction" over challenges to certain "procedural aspects" of the Medicare Program (Pet. App. 8a), and it elected to do the same. Thus, although the court of appeals acknowledged that "the eventual result of this suit may cause an increase in amounts of reimbursement" for services rendered by family physicians (*ibid.*), it nevertheless held that the suit is not barred by 42 U.S.C. 1395ff and *Erika* because respondents are challenging the "mechanism" for computing the reasonable charge for particular services, not the reasonable charge itself (Pet. App. 8a-9a).

The court of appeals further concluded that the district court's exercise of federal question jurisdiction

under 28 U.S.C. 1331 was not barred by 42 U.S.C. 405(h), which is incorporated into the Medicare Act by 42 U.S.C. 1395ii (Pet. App. 9a-11a). The court acknowledged that in *Weinberger* v. *Salfi*, 422 U.S. 749 (1975), and subsequent decisions, this Court had held that the third sentence of Section 405(h) prohibits a district court from exercising jurisdiction under 28 U.S.C. 1331 over any claim "arising under" the Social Security Act. But it noted that in *Salfi* and the other decisions, this Court had referred to an alternative method for obtaining judicial review pursuant to 42 U.S.C. 405(g). Because there is no provision for review of Part B Medicare claims pursuant to 42 U.S.C. 405(g), the court of appeals held that 42 U.S.C. 405(h) should not be construed to preclude jurisdiction under 28 U.S.C. 1331 over a suit arising under Part B. Pet. App. 10a-11a.

b. On the merits, the court of appeals invalidated 42 C.F.R. 405.504(b) and BC/BSM's methodology for calculating payments for physicians' services by reference to the separate prevailing charge screens (Pet. App. 11a-14a). The court rejected the Secretary's contention that the provision in 42 C.F.R. 405.504(b) for separate charge screens furthers the legislative intent to have reimbursement reflect the actual charge patterns in the community. The court believed instead that the "touchstone of [42 U.S.C. 1395u(b)(3)] is that similar services, once determined, are to be compensated equally, regardless of who performs them" (Pet. App. 12a). The court further explained that because the reimbursement approach BC/BSM followed might create an added incentive for physicians to become specialized and for patients to seek specialized care, "the regulation as applied violates 42 U.S.C. § 1395a, prohibiting in-

fringement of a patient's free choice of a physician" (Pet. App. 14a). The court therefore remanded the case to the Secretary "with instructions to consider similar services in an equal manner regardless of who performs that service" (*id.* at 15a).

3. The Secretary and BC/BSM then filed a petition for a writ of certiorari, arguing that the court of appeals' jurisdictional ruling was contrary to the preclusions of review in 42 U.S.C. 1395ff and 405(h), as interpreted by this Court in *Erika* and the intervening decision in *Ringer*. The Court granted the petition, vacated the judgment of the court of appeals, and remanded the case to the court of appeals for further consideration in light of *Ringer*. *Heckler* v. *Michigan Academy of Family Physicians*, No. 84-120 (Oct. 1, 1984).

4. On remand, the court of appeals at first ordered the case dismissed for lack of jurisdiction, explaining that "the principles stated by the Supreme Court in *Heckler* v. *Ringer* require us to find that the federal courts lack jurisdiction over the present case" (Pet. App. 16a). However, on respondents' petition for rehearing, the panel held that *Ringer* and *Erika* do not preclude the exercise of jurisdiction in this case (Pet. App. 17a-22a).

The court of appeals acknowledged that this Court, in footnote 4 of its opinion in *Ringer*, held that judicial review was barred in that case insofar as it arose under Part B of the Medicare Program (Pet. App. 21a). But although the Court in *Ringer* expressly relied for this proposition on its prior decision in *Erika* (see *Ringer*, slip op. 5 n.4), which in turn relied on the preclusion of review in 42 U.S.C. 1395ff (see 456 U.S. at 206-211), the court of appeals stated that "[i]n reaching its decision in *Heckler* v. *Ringer*[,]

the Supreme Court did not rely on § 1395ff" (Pet. App. 18a n.2). Presumably for this reason, the court of appeals did not discuss 42 U.S.C. 1395ff further.

With regard to the additional preclusion of review in 42 U.S.C. 405(h), the court of appeals acknowledged that this Court held in *Ringer* that the challenge to the ruling there at issue fell within the prohibition in Section 405(h) against the exercise of jurisdiction under 28 U.S.C. 1331 (Pet. App. 19a-20a) and that the application of Section 405(h) does not depend on whether judicial review of the particular claim is otherwise available under the Social Security Act itself (Pet. App. 21a-22a). But without explaining why *Ringer* was not therefore controlling, the court of appeals held that the district court *did* have jurisdiction under 28 U.S.C. 1331 to entertain respondents' challenge to a regulation that affected the amount of benefits payable. The court relied on nothing more than a "presumption" favoring judicial review and its notion that "for every right there must be a remedy" (Pet. App. 22a). The court of appeals further concluded, without elaboration, that *Ringer* does not foreclose judicial review "by a party other than a claimant for benefits" (Pet. App. 21a, 22a).

SUMMARY OF ARGUMENT

I

A. The text and legislative history of the Medicare Act establish that Congress has foreclosed judicial review of matters pertaining to the amount of benefits under Part B of the Medicare Program. The only Section of the Act that provides for any form of review of the amount of benefits under Part B is 42 U.S.C. 1395u(b)(3), which confers a right to a hearing by the carrier on a disputed claim but makes no

provision for administrative review by the Secretary or judicial review by the courts. Moreover, under 42 U.S.C. 1395ff, a beneficiary is expressly granted a right to judicial review concerning his entitlement to participate in the Part A or Part B Medicare Program and to judicial review of the "amount of benefits under Part A." But Section 1395ff conspicuously fails to provide for judicial review of the amount of benefits under Part B. This omission in itself furnishes persuasive evidence that Congress deliberately intended to foreclose such review. As this Court observed in *United States* v. *Erika, Inc.*, 456 U.S. 201, 211 (1982), the legislative history of the original Medicare Act and the 1972 amendments to 42 U.S.C. 1395ff "unambiguously support[s]" this reading of the statutory text. The Court accordingly held in *Erika* that judicial review is entirely foreclosed under Part B, and the Court adhered to that view in *Heckler* v. *Ringer*, No. 82-1772 (May 14, 1984), slip op. 5 n.4.

This case falls squarely within the preclusion of review that Congress twice enacted and this Court recognized in *Erika* and *Ringer*, because the prevailing charge screens respondents challenge operate as a ceiling on the amount of benefits payable for covered services under Part B. Indeed, it is particularly clear that Congress did not intend to permit judicial review of a carrier's determination of the prevailing charge level, because that determination depends on the ascertainment and analysis of legislative facts that are peculiarly within the expertise of the Secretary and the carriers. This conclusion is confirmed by the text of 42 U.S.C. 1395u(b)(3), which requires only that the carrier's methodology for determining the prevailing charge level be "acceptable to the Secretary," and by the recent enact-

ment of an express exception to the judicial review provisions for similar determinations under Part A.

B. The various attempts by the court of appeals and respondents to avoid the preclusion of review under 42 U.S.C. 1395ff and this Court's decisions in *Erika* and *Ringer* are without merit. This case in fact is indistinguishable from *Erika*, because the plaintiff in that case likewise challenged the carrier's methodology for calculating the prevailing charge level for certain Part B services. *Erika* and *Ringer* also make clear that, contrary to respondents' submission, 42 U.S.C. 1395ff does not permit judicial review of so-called "statutory" issues. In each of those cases the plaintiff alleged that the carrier's actions under Part B were inconsistent with the Medicare Act, but the Court nevertheless held that judicial review was barred by Section 1395ff. Nor does it matter that respondents have characterized their suit as a challenge to the Secretary's regulation authorizing the establishment of separate prevailing charge screens, rather than to the amount of benefits paid by reference to the screens themselves. In *Erika* and *Ringer* the plaintiffs challenged the validity of instructions by the Secretary that were binding upon the carrier in the same manner as a regulation, but this Court nevertheless held that judicial review under Part B was precluded.

II

A. The conclusion compelled by 42 U.S.C. 1395ff —that judicial review of a regulation affecting the amount of benefits under Part B is barred because such review is not affirmatively authorized by the Social Security Act—is confirmed by 42 U.S.C. 405(h). The second sentence of Section 405(h) provides that no decision by the Secretary shall be re-

viewed by any "tribunal" except as provided in the Social Security Act itself. The carrier is the Secretary's agent in rendering decisions under Part B. The second sentence of Section 405(h) therefore bars review by a judicial "tribunal" of the carrier's decision regarding the amount of benefits under Part B.

In addition, the third sentence of Section 405(h) specifically precludes the bringing of an action under 28 U.S.C. 1331 to recover on any claim "arising under" the Social Security Act. This Court's decisions in *Ringer* and *Weinberger* v. *Salfi*, 422 U.S. 749 (1975), make clear that this jurisdictional bar is fully applicable where, as here, the plaintiff seeks only declaratory and injunctive relief or characterizes his challenge as "procedural" in nature. *Ringer* also confirms that the third sentence of Section 405(h) is fully applicable where, as under Part B, judicial review is not otherwise made available by the Social Security Act itself.

B. There also is no support for the court of appeals' holding that *Ringer* does not bar judicial review "by a party other than a claimant for benefits" (Pet. App. 22a). One of the plaintiffs in *Ringer* had not submitted a claim for benefits, but the Court nevertheless held that federal question jurisdiction was precluded by Section 405(h). And in *Erika*, the Court foreclosed the supplier of Part B services, not just the beneficiary, from obtaining judicial review. By contrast, under the Part A Program, Congress has expressly afforded providers of services a right of judicial review. See 42 U.S.C. 1395*oo*(f). The fact that Congress did not afford a similar right to their counterparts under Part B is a persuasive indication that Congress deliberately foreclosed such suits by physicians.

III

The court of appeals in the end was forced to fall back on a presumption in favor of judicial review. However, any such presumption under Part B necessarily is overcome by this Court's construction of congressional intent in *Erika* and *Ringer*. Respondents cannot avoid those holdings by relying on a presumption of judicial review where the constitutionality of an Act of Congress is challenged, since they have not attacked the validity of any provisions of the Social Security Act. The Court need not decide whether Congress has foreclosed judicial review of constitutional objections to determinations made in the administration of the Part B Program, because here, as in *Ringer* (slip op. 5 n.4), respondents' constitutional claims are too insubstantial to support subject matter jurisdiction in any event.

ARGUMENT

THE DISTRICT COURT DID NOT HAVE JURISDICTION TO ENTERTAIN RESPONDENTS' CHALLENGE TO A REGULATION AFFECTING THE CARRIER'S DETERMINATION OF THE PREVAILING CHARGE LEVEL FOR PHYSICIANS' SERVICES UNDER PART B OF THE MEDICARE PROGRAM

Respondents invoked the jurisdiction of the district court under 28 U.S.C. 1331 to challenge a regulation that authorizes a carrier to develop separate prevailing charge screens to calculate the amount of Part B Medicare benefits paid for physicians' services. Judicial review of such matters is barred by two separate provisions of the Social Security Act. The first is 42 U.S.C. 1395ff, which provides the exclusive avenue of judicial review for participants in the Medicare Program but does not provide for judicial review of

the amount of benefits under Part B. The second is 42 U.S.C. 405(h), which prohibits the review by any "tribunal" of decisions on claims for benefits under the Social Security Act (except as provided under that Act) and specifically precludes the bringing of an action under 28 U.S.C. 1331 to recover on any claim "arising under" the Social Security Act.

The court of appeals' holding that the district court had jurisdiction notwithstanding these preclusions of review is flatly inconsistent with this Court's decisions in *United States* v. *Erika, Inc.*, 456 U.S. 201 (1982), and *Heckler* v. *Ringer*, No. 82-1772 (May 14, 1984). Those cases, like this one, involved challenges to a rule or instruction of general applicability that bound the carrier and had the effect of limiting the amount of benefits the carrier could pay on individual benefit claims. The Court nevertheless held that judicial review was foreclosed under Part B.

The court of appeals' failure to follow *Erika* and *Ringer* unfortunately is typical of the manner in which some lower courts continue to disregard the clear intent of Congress and the clear pronouncements of this Court on questions of jurisdiction arising under the massive Social Security programs. Congress has carefully specified the circumstances and manner in which judicial review is available under the Social Security Act, in the interest of promoting efficiency and fairness in the administration of the Act and preventing the courts from being flooded with minor disputes that Congress determined were more appropriately left to the Secretary to resolve. This congressional policy is particularly compelling under Part B of the Medicare Program, in which more than 150 million claims are submitted annually. *McClure*, 456 U.S. at 190.

The decision below, if affirmed by this Court, would permit judicial review under Part B whenever a claimant characterizes his challenge to the amount of benefits payable under Part B as a challenge to a regulation of the Secretary or a general policy of the carrier that has a bearing on the disposition of individual claims. Virtually any claimant could cast his challenge in such terms. The result would be to foster the very potential for widespread litigation over minor disputes that threatened to ensue prior to this Court's decision in *Erika*. The Court adhered to its unanimous holding in *Erika* just two Terms ago in *Ringer*, and there is no basis for a different result here.

I. JUDICIAL REVIEW OF THE AMOUNT OF BENEFITS UNDER PART B OF THE MEDICARE PROGRAM IS FORECLOSED BY 42 U.S.C. 1395ff

A. The Text And Legislative History Of The Medicare Act And This Court's Decisions In *Erika* And *Ringer* Bar Judicial Review Of Questions Relating To The Amount Of Benefits Under Part B

1. The Medicare Act provides for only limited review of questions of coverage and the amount of benefits payable under Part B of the Medicare Program. The relevant statutory provisions do not contemplate judicial review.

The carrier with which the Secretary has contracted to administer the Part B Program may make payment for services only on the basis of an itemized bill submitted by the beneficiary or by an assignee of the Medicare reimbursement claim (generally, the physician or other person who furnished the services). 42 U.S.C. 1395u(b)(3)(B)(i) and (ii). The limited review mechanism Congress has provided is trig-

gered by the submission of this "request for payment" (42 U.S.C. 1395u(b)(3)(C)). 42 C.F.R. 405.251, 405.252, 405.803.

If the carrier denies the request for payment and the amount in controversy is $100 or more, the claimant is entitled to "an opportunity for a fair hearing by the carrier." 42 U.S.C. 1395u(b)(3)(C). From the outset of the Medicare Program, the Secretary's regulations implementing this statutory hearing requirement have provided that the carrier hearing officer is bound by implementing regulations, instructions and other guidance issued by HCFA. 42 C.F.R. 405.860. Those regulations also have provided from the outset that the hearing officer's decision is "final and binding upon all parties to the hearing" (42 C.F.R. 405.835; see 42 U.S.C. 405(h)). This "final and binding" effect necessarily applies to the interpretation and application of provisions of the Act, regulations and HCFA instructions on which the decision is based.[4]

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[4] The regulations that require the carrier hearing officer to follow the Secretary's regulations, instructions and policies and declare his decision to be "final and binding" were promulgated in 1967 (43 Fed. Reg. 18028) and remained in effect in 1972. See 20 C.F.R. 405.835, 405.860 (1971). In that year, Congress amended 42 U.S.C. 1395u(b)(3)(C) to add the $100 amount-in-controversy prerequisite for entitlement to a hearing by the carrier (see Pub. L. No. 92-603, § 262, 86 Stat. 1448) and amended 42 U.S.C. 1395ff to reaffirm the preclusion of judicial review under Part B except with respect to an individual's entitlement to enroll in the Part B Program (see Pub. L. No. 92-603, § 299*o*(a), 86 Stat. 1464, discussed at pages 23-24, *infra*). Because Congress in 1972 revisited the Part B Program generally and revised other aspects of the review procedures under Part B—but left in place the regulatory provisions just discussed—the 1972 amendments may

There is no provision in 42 U.S.C. 1395u(b)(3)(C) for review by the Secretary of the carrier's decision on an individual claim. See 42 C.F.R. 405.502(d). There also is no provision in that section for *judicial* review of the carrier's decision or of regulations issued by the Secretary that might have affected that decision. Thus, nothing in 42 U.S.C. 1395u(b)(3)(C)—the only section of the Act specifically dealing with review of claims under Part B—supports a right of judicial review under Part B.

2. The only provisions for judicial review at the behest of a beneficiary under the Medicare Program are contained in a different section of the Act, 42 U.S.C. 1395ff. In Subsection (a) of 42 U.S.C. 1395ff, Congress provided for the Secretary to determine whether an individual is entitled to participate in the Part A and Part B Programs and to determine "the amount of benefits under Part A * * *." A person who is dissatisfied with the Secretary's decision regarding his right to participate in either Part A or Part B is entitled to an administrative hearing pursuant to 42 U.S.C. 405(b) and to judicial review pursuant to 42 U.S.C. 405(g), without regard to the amount in controversy. 42 U.S.C. 1395ff(b)(1)(A) and (B). A person who is dissatisfied with the Secretary's determination regarding the "amount of benefits under Part A" also has a right to administrative and judicial review pursuant to 42 U.S.C. 405(b) and (g), but only if the amount in contro-

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properly be viewed as a congressional ratification of the provisions making the carrier's application of regulations and instructions "final and binding" on the claimant. *Lindahl* v. *OPM*, No. 83-5954 (Mar. 20, 1985), slip op. 12 & n.15; *Merrill Lynch, Pierce, Fenner & Smith* v. *Curran*, 456 U.S. 353, 378-382 (1982).

versy is at least $100 and $1,000, respectively. 42 U.S.C. 1395ff(b)(1)(C) and (2). However, 42 U.S.C. 1395ff conspicuously fails to provide a corresponding right to judicial review of the "amount of benefits" under Part B. As the Court observed in *Erika*, "[i]n the context of the statute's precisely drawn provisions, this omission provides persuasive evidence that Congress deliberately intended to foreclose further review of such claims." 456 U.S. at 208. See also *Block* v. *Community Nutrition Institute*, No. 83-458 (June 4, 1984), slip op. 6.[5]

3. The legislative history "confirms" and "explains [the] logic" of this preclusion of review. *Erika*, 456 U.S. at 208. The Senate Report on the original Medicare Act described the operation of 42 U.S.C. 1395ff as follows (S. Rep. 404, 89th Cong., 1st Sess. 54-55 (1965) (emphasis added)):

> Hearings and judicial review are * * * provided for where an individual is dissatisfied with a determination as to the amount of benefits under

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[5] Congress also has afforded a beneficiary a right to judicial review on questions of coverage in certain limited circumstances under 42 U.S.C. 1320c-4, if the amount in controversy is $2000 or more. That Section applies where a peer review organization, pursuant to contract with the Secretary, has determined that certain medical services are not covered by Medicare because they are or were custodial or not reasonable and necessary, or where services are proposed to be furnished in a hospital when they could be furnished as effectively but more economically on an out-patient basis. 42 U.S.C. 1320c-3(a)(1) and (2). This peer review system has been implemented to date only with respect to services furnished in a hospital or other institution (50 Fed. Reg. 15364 (1985)). Although some Part B services may be affected by the new peer review procedures, there is no right to judicial review under 42 U.S.C. 1320c-4 on the question of the amount of benefits payable for services that are found to be covered.

> the [Part A] hospital insurance plan if the amount in controversy is $1,000 or more. (Under the supplementary plan [Part B], carriers, not the Secretary, would review beneficiary complaints regarding the amount of benefits, and *the bill does not provide for judicial review of a determination concerning the amount of benefits under part B where claims will probably be for substantially smaller amounts than under part A.)* * * * *It is intended that the remedies provided by these review procedures will be exclusive.*

See also H.R. Rep. 213, 89th Cong., 1st Sess. 47 (1965).

Congress reiterated this intent in 1972, when it amended 42 U.S.C. 1395ff to make clear that judicial review is not available on questions of coverage or benefit amounts, unless the claim arises under Part A and the amount in controversy is at least $1,000.[6] Senator Bennett, the sponsor, stated that the amendment was intended to ensure that 42 U.S.C. 1395ff "is not interpreted to mean [that the beneficiary] can take the question of the Federal claim to court" and to confirm "the original intention of the law that the courts can determine only eligibility [to participate in Part A or Part B]" (118 Cong. Rec. 33992

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[6] Some courts had construed the Act as originally passed in 1965 (see 42 U.S.C. (1970 ed.) 1395ff(b)) to permit judicial review of coverage questions under Parts A and B without regard to the amount in controversy. See, *e.g.*, *Ridgely* v. *Secretary of Dep't of Health, Education & Welfare*, 345 F. Supp. 983, 986-988 (D. Md. 1972), aff'd, 475 F.2d 1222 (4th Cir. 1973); *Bohlen* v. *Richardson*, 345 F. Supp. 124 (E.D. Pa. 1972), aff'd, 483 F.2d 918 (3d Cir. 1973); *Cardno* v. *Finch*, 311 F. Supp. 251 (E.D. La. 1970). See also *Erika*, 456 U.S. at 209 & n.12.

(1972)). The Conference Report likewise stated with respect to the 1972 amendment (H.R. Conf. Rep. 92-1605, 92d Cong., 2d Sess. 61 (1972) (emphasis added)):

> The Senate amendment added a new section to the House bill which would make clear that *there is no authorization for an appeal to the Secretary or for judicial review on matters solely involving amounts of benefits under Part B*, and that insofar as Part A amounts are concerned, appeal is authorized only if the amount in controversy is $100 or more and judicial review only if the amount in controversy is $1,000 or more.

As the Court observed in *Erika*, these expressions of legislative intent "unambiguously support" an interpretation of Section 1395ff that bars all judicial review of matters concerning the "amount of benefits" under Part B. The Court adhered to this view in *Ringer* and held that judicial review was entirely foreclosed insofar as that case arose under Part B. *Ringer*, slip op. 5 n.4. See also *Lindahl* v. *OPM*, No. 83-5954 (Mar. 20, 1985), slip op. 21 n.28 (the legislative history discussed in *Erika* confirms "Congress' intent absolutely to preclude review").

4. This case falls squarely within the preclusion of review that Congress intended, because it unquestionably concerns the "amount of benefits under Part B" (H.R. Rep. 213, *supra*, at 47; H.R. Conf. Rep. 92-1605, *supra*, at 61). Respondents challenge the particular prevailing charge screens that BC/BSM has applied to services by certain family physicians. The prevailing charge level establishes a ceiling on the "reasonable charge" for the services of such physicians. 42 U.S.C. 1395u(b)(3). Because the amount of benefits payable under Part B

is 80% of the reasonable charge, respondents' challenge to BC/BSM's prevailing charge ceilings necessarily constitutes a challenge to the amount of benefits payable on individual claims under Part B.

The circumstances of this case also directly implicate the policy considerations that underlie the preclusion of review under Part B. The only illustration the district court offered regarding the effect of the differing charge screens utilized by BS/BSM concerned the prevailing fee limitations in the Lansing area, which is the residence of respondent Diedrich, a Part B beneficiary. The district court observed that the prevailing charge in the case of an initial comprehensive visit was $50 for specialists and $25 for non-specialists, and in the case of a follow-up visit was $12.30 for specialists and $10.70 for non-specialists. Pet. App. 32a. As a result, in many instances the net effect of the separate charge screens was $1.60 per visit. These are precisely the sort of "quite minor" and "trivial" disputes under the Part B program that Congress intended to keep out of the courts. *Erika*, 456 U.S. at 209, 210 n.13, quoting 118 Cong. Rec. 33992 (1972) (remarks of Sen. Bennett).

5. Even if, contrary to this Court's holding in *Erika* and *Ringer*, respondents were correct that Congress has not entirely foreclosed judicial review of all matters bearing on the calculation of the amount of benefits under Part B, it nevertheless is clear that Congress did not intend to permit a Part B beneficiary or his assignee to seek judicial review of the "prevailing charge" aspect of benefit amount determinations.

a. The establishment of the prevailing charge levels for various services in a particular locality de-

pends on the gathering and analysis of legislative facts, including an expert judgment regarding what services are sufficiently similar to be grouped together for these purposes. " '[T]he proper amount of these charges is a matter peculiarly suited to determination by a specialized agency,' " and judicial review of such determinations would "involve the courts in the complex and detailed task of 'ascertaining the appropriate medical charges for technical services—based on facts which vary from community to community' " (*Kechijian* v. *Califano*, 621 F.2d 1, 3 (1st Cir. 1980), quoting *St. Louis University* v. *Blue Cross Hospital Service*, 537 F.2d 283, 289 (8th Cir.), cert. denied, 429 U.S. 977 (1976)). There is no reason to believe that Congress intended to permit an individual beneficiary or his physician to challenge such determinations in court. Cf. *Heckler* v. *Campbell*, 461 U.S. 458, 467-468 (1983).[7]

b. The language of 42 U.S.C. 1395u(b)(3) in fact demonstrates that Congress did not intend that result. As explained above (see page 6, *supra*), Congress amended Section 1395ff in 1972 to impose a ceiling on the "reasonable charge" for particular services. The ceiling is the prevailing charge level that, "on the basis of statistical data and methodology acceptable to the Secretary," would cover 75% of the customary charges made for similar services in the locality during the preceding calendar year.

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[7] It also is essential that the annual prevailing charge screens be established promptly so that they can be applied to the processing of individual claims at the beginning of each fiscal year. Permitting judicial challenges to the prevailing charge screens would substantially undermine the need for expedition and create uncertainty regarding the payment of vast numbers of claims. Cf. *Morris* v. *Gressette*, 432 U.S. 491 (1977).

The very regulation respondents challenge in this suit, 42 C.F.R. 405.504(b), expressly authorizes a carrier to utilize separate charge screens to calculate the prevailing charge level, and that methodology therefore plainly is "acceptable to the Secretary" within the meaning of 42 U.S.C. 1395u(b)(3). The quoted passage makes clear that general oversight by the Secretary was the means Congress chose to assure that carriers properly implement the statutory and regulatory provisions that address the complex calculation of prevailing charge levels. Congress deemed it sufficient that the carrier's statistical data and methodology be "acceptable to the Secretary"; it did not contemplate intervention by the courts.

c. Congress's recent enactment of the prospective payment system under the Part A Medicare Program provides a further indication that Congress did not intend to permit judicial review of the prevailing charge level under Part B. Under the new prospective payment system, Congress directed the Secretary to establish diagnosis related groups (DRGs). Payment for services within each DRG then is to be made at a flat rate, generally without regard to a particular provider's actual cost experience. See 42 U.S.C. (Supp. I) 1395ww(d). Although a provider retains the right to administrative and judicial review under 42 U.S.C. 1395*oo* with respect to the amount it will be reimbursed under Part A if the amount in controversy is $10,000 or more, Congress expressly foreclosed administrative or judicial review under 42 U.S.C. 1395*oo* (or otherwise) of the Secretary's "establishment of diagnosis related groups [and] of the methodology for the classification of discharges within such groups." 42 U.S.C. (Supp. I) 1395ww(d)(7)(B). See also 42 U.S.C.

(Supp. I) 1395*oo*(g)(2). The legislative history explains that Congress precluded review "because of the complexity of such action and the necessity of maintaining a workable payment system" (H.R. Rep. 98-25, 98th Cong., 1st Sess. 143 (1983)). See also S. Rep. 98-23, 98th Cong., 1st Sess. 57 (1983)).

These same considerations weigh heavily against judicial review of prevailing charge screens under Part B. The determination in the Part B Program of what services are "similar" for purposes of grouping them together under the same prevailing charge screen is directly analogous to the establishment of DRGs in the Part A Program and the classification of services within DRGs. The fact that Congress expressly foreclosed judicial review of determinations under Part A that depend on the ascertainment and analysis of legislative facts, even though it otherwise has afforded providers a right to administrative and judicial review under Part A, confirms that Congress did not intend to allow judicial review of prevailing charge level limitations under the Part B Program, in which Congress has completely foreclosed judicial review.

B. The Court Of Appeals' And Respondents' Efforts To Avoid 42 U.S.C. 1395ff And The Holdings In *Erika* And *Ringer* Are Without Merit

In its original opinion finding jurisdiction in this case, the court of appeals candidly conceded that it was following the lead of other courts of appeals that, even "[i]n the wake of *Erika*, * * * ha[d] strenuously endeavored to find jurisdiction over various types of challenges to the procedural aspects of the Medicare part B program despite the language of

[42 U.S.C.] 1395ff" (Pet. App. 8a). The court relied in particular on *Ringer* v. *Schweiker*, 697 F.2d 1291 (9th Cir. 1982), and *Starnes* v. *Schweiker*, 715 F.2d 134 (4th Cir. 1983). See Pet. App. 8a, 9a, 10a, 11a. The court of appeals cited those decisions for the proposition that although 42 U.S.C. 1395ff and *Erika* preclude judicial review of the actual amount of reimbursement in a particular case, they do not bar judicial review of the "mechanism" utilized by the carrier to determine the amount of reimbursement or the actions of the Secretary in the administration of the Part B Program (such as her promulgation of the regulation at issue in this case). See Pet. App. 8a-9a, 10a-11a.

Of course, subsequent to the court of appeals' original opinion, this Court reversed the Ninth Circuit's decision in *Ringer*. It also vacated the Fourth Circuit's decision in *Starnes* and remanded that case for further consideration in light of *Ringer*. See *Heckler* v *Starnes*, No. 83-1149 (June 4, 1984). The Fourth Circuit itself then held in *Starnes* that *Ringer* required dismissal of the case for lack of jurisdiction. *Starnes* v. *Schweiker*, 748 F.2d 217 (1984), cert. denied, No. 84-1309 (Apr. 15, 1985). The precedential support the court of appeals once perceived for its attempt to distinguish *Erika* therefore has been eliminated. See also *Hatcher* v. *Heckler*, 772 F.2d 427, 429-430 (8th Cir. 1985). In any event, as we explain below, *Erika* itself made clear that the preclusion of review in 42 U.S.C. 1395ff applies to challenges to the manner in which the reasonable charge is calculated as well as challenges to the precise amount of benefits in a particular case, and *Ringer* confirms that interpretation.

1. This case is indistinguishable from *Erika* in all material respects. In *Erika*, the plaintiff challenged the carrier's decision to calculate the prevailing charge level on the basis of prices charged at the beginning of the preceding calendar year, without taking into account subsequent price increases. The plaintiff contended that this approach was inconsistent with the statutory requirement in 42 U.S.C. 1395u (b) (3) that the prevailing charge level be calculated on the basis of "customary charges made for similar services in the same locality *during* the last preceding calendar year" (emphasis added). See 456 U.S. at 204-205 & n.2; *Erika, Inc.* v. *United States*, 634 F.2d 580, 588-589 (Ct. Cl. 1980). This Court, however, unanimously held that judicial review was barred. 456 U.S. at 206-211. Like the plaintiff in *Erika*, respondents challenge the carrier's determination of the prevailing charge level. The only difference is that respondents take issue with the carrier's identification of which services are "similar" for purposes of that calculation, while in *Erika* the challenge was to the timing of the calculation. This difference has no bearing on the availability of judicial review. *Erika* therefore squarely controls this case.

2. Respondents next argue (Br. in Opp. 11, 12, 15, 16, 17) that 42 U.S.C. 1395ff should not be construed to preclude judicial review of what they term "statutory" issues that may arise in connection with the carrier's determination and payment of benefits. This assertion also is foreclosed by *Erika* and *Ringer*. As we have just explained, the plaintiff in *Erika* contended that the carrier's formulation of the prevailing charge screen was contrary to the Social Security Act (456 U.S. at 205; 634 F.2d at 588-591), but this Court nevertheless held that judicial review

was foreclosed. Similarly, the plaintiffs in *Ringer* contended that the Secretary's instructions that required the carrier to refuse to pay any amount of benefits for BCBR surgery violated the Social Security Act and the Administrative Procedure Act (see *Ringer*, slip. op. 7 & n.7), but this Court nevertheless held that judicial review was foreclosed under 42 U.S.C. 1395ff and *Erika* insofar as the case concerned the Part B Program (*Ringer*, slip op. 5 n.4).[8]

3. Nor can respondents avoid the foreclosure of review under 42 U.S.C. 1395ff and *Erika* and *Ringer* by characterizing this suit as a challenge to a regulation issued by the Secretary, rather than to the amount of benefits paid by the carrier. This conclusion is evident from the structure of 42 U.S.C. 1395ff. In 42 U.S.C. 1395ff(b), Congress has authorized judicial review of the "amount of benefits under part A." That amount is to be determined "in accordance with regulations prescribed by [the Secretary]." 42 U.S.C. 1395ff(a). On judicial review

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[8] Respondents' submission in this regard also is inconsistent with the legislative history of the 1972 amendments to 42 U.S.C. 1395ff. As we have explained (see note 6, *supra*), some courts had held prior to 1972 that 42 U.S.C. 1395ff did not foreclose judicial review on questions of coverage under Part A or Part B, as distinguished from the amount of benefits payable. One court that had so held in a Part B case sought to justify this result in part on the ground that questions of coverage are more likely to present issues of statutory construction appropriate for judicial resolution. See *Bohlen* v. *Richardson*, 345 F. Supp. at 130; 483 F.2d at 921 & n.13. When Congress amended 42 U.S.C. 1395ff in 1972 to overrule this and other decisions and preclude review on questions of coverage, it necessarily rejected the notion that judicial review is available under Part B with respect to claims for benefits that are couched as issues of statutory construction.

pursuant to 42 U.S.C. 1395ff(b), the beneficiary may challenge the validity of any such regulations that limit the amount of benefits paid on the claim or that guide the fiscal intermediary or the ALJ in computing that amount. See *Ringer*, slip op. 10-11, 13. The corresponding *foreclosure* of judicial review of the "amount of benefits" under Part B likewise must apply to challenges to regulations issued by the Secretary that limit the amount of benefits that a carrier may pay on a particular Part B claim or that guide the carrier in calculating the benefit amount.[9] Indeed, in order even to have standing to bring this suit, respondents must rely on the effect of the challenged regulation on the amount of benefits payable on individual Part B claims. Compare *Ringer*, slip op. 11-12.

Moreover, in *Erika* itself, the plaintiff's claim to increased benefits was based in part on a challenge to instructions issued by the Secretary that bound the carrier in the same manner as formal regulations (see *Ringer*, slip op. 3-4; 42 C.F.R. 405.860) and limited the amount of benefits the carrier could pay. See *Erika, Inc.* v. *United States*, 634 F.2d at 590-591. This Court nevertheless held that judicial review was unavailable.

If there were any doubt remaining on this point after *Erika*, it was dispelled by *Ringer*. That case

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[9] As this Court observed in *Ringer* (slip op. 13), the determination by the Secretary whether to promulgate a generally applicable rule to resolve a particular issue, or instead to permit individual adjudication of that question by the carriers or fiscal intermediaries, is a matter committed to the Secretary's discretion. The availability of judicial review should not depend on whether the Secretary has chosen to issue a regulation on a particular issue or instead to leave the matter to case-by-case adjudication by the carriers.

involved a challenge to a regulation and HCFA instruction that prohibited the payment of *any* benefits for a particular medical service. *Ringer*, slip op. 2-5. Yet the Court held that judicial review was barred by *Erika* insofar as the case concerned the Part B Program. *Ringer*, slip op. 5 n.4. The Court so held even though the plaintiffs in *Ringer*, like respondents herein, did not actually request the Court to award benefits, but instead sought only an invalidation of the regulation and instruction that would bind the carrier in its subsequent adjudication of individual claims for benefits. Slip op. 9-10, 12. Because the Court in *Ringer* explicitly relied on *Erika*, which in turn relied on the foreclosure of review in 42 U.S.C. 1395ff, the court of appeals in this case was simply mistaken when it stated in its most recent opinion that "[i]n reaching its decision in [*Ringer*], the Supreme Court did not rely on § 1395ff" (Pet. App. 18a n.2). And this error might explain the court of appeals' otherwise inexplicable assertion that its jurisdictional holding did not conflict with *Ringer* (*id.* at 22a).

II. THE EXERCISE OF JURISDICTION UNDER 28 U.S.C. 1331 OVER CLAIMS ARISING UNDER THE MEDICARE PROGRAM IS BARRED BY 42 U.S.C. 405(h)

The correctness of the result indicated by 42 U.S.C. 1395ff standing alone—that judicial review of a regulation affecting the amount of benefits under Part B is foreclosed because it is not expressly authorized by the Social Security Act—is confirmed by 42 U.S.C. 405(h).[10]

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[10] By virtue of 42 U.S.C. 1395ii, Section 405(h) is made applicable to the Medicare Program "to the same extent" as it is applicable to Title II of the Act.

A. This Court's Decisions In *Salfi* And *Ringer* Establish That Section 405(h) Bars Federal Question Jurisdiction In This Case

1. The second sentence of Section 405(h) provides that "[n]o findings of fact or decision of the Secretary shall be reviewed by any person, *tribunal*, or governmental agency *except as herein provided*" (emphasis added). This sentence embodies a general rule under the Social Security Act that judicial review of administrative decisions on claims for benefits is unavailable except where expressly authorized by that Act. *Salfi*, 422 U.S. at 759 n.6; *Califano* v. *Sanders*, 430 U.S. 99, 110 (1977) (Stewart, J., concurring). Under the Part B Medicare Program, the carriers render decisions on behalf of the Secretary (see *McClure*, 456 U.S. at 190), and the Secretary is the real party in interest in any litigation (*Erika*, 456 U.S. at 206 n.4, quoting 42 C.F.R. 421.5(b)). The preclusion of review in the second sentence of 42 U.S.C. 405(h) therefore applies to decisions by the carriers under Part B. Because Congress has not affirmatively provided in the Social Security Act itself for review by a judicial "tribunal" of the carrier's decisions under Part B, the second sentence of Section 405(h) precludes such review.

2. The third sentence of Section 405(h) further provides that "[n]o action against the * * * Secretary * * * shall be brought under section[] 1331 * * * of title 28 to recover on any claim arising under this subchapter." The court of appeals' holding that the district court had jurisdiction under 28 U.S.C. 1331 directly contravenes this "sweeping and direct" jurisdictional bar as well (*Salfi*, 422 U.S. at 757).

a. In its original opinion, the court of appeals was of the view that Section 405(h) and *Salfi* did not bar jurisdiction under 28 U.S.C. 1331 because this case "involves not a challenge to an individual amount of reimbursement, but instead a challenge to a regulation by the Secretary establishing the procedure under which reimbursement schedules should be determined" (Pet. App. 10a). This narrow view of the reach of Section 405(h) was demonstrably incorrect even at the time the court of appeals rendered its first opinion.

This Court's construction of the third sentence of Section 405(h) in *Salfi* was not dependent upon the fact that the plaintiffs sought an actual award of benefits. The plaintiffs in *Salfi* also sought a declaratory judgment that the statutory provisions were unconstitutional and injunctive relief prohibiting the Secretary from relying on those provisions to deny benefits in administrative proceedings (App. at 12-13, *Weinberger* v. *Salfi*, *supra*), but the Court did not find jurisdiction under 28 U.S.C. 1331 over those aspects of the case either. 422 U.S. at 764. See *Ringer*, slip op. 12. *Salfi* thus made clear that Section 405(h) does not permit a beneficiary to split off one legal issue bearing on the merits of his claim for benefits and present that issue in an independent action for declaratory or injunctive relief under 28 U.S.C. 1331, so that he then can pursue his reimbursement claim in administrative proceedings armed with the judicial ruling on the discrete legal issue.[11]

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[11] At the time of the court of appeals' first decision, a number of other courts of appeals had read *Salfi* to prevent a claimant from seeking to establish his future entitlement to benefits in a separate action under 28 U.S.C. 1331. See, *e.g.*, *Attorney Registration & Disciplinary Comm'n* v. *Schweiker*, 715 F.2d

Nor had there been any suggestion by this Court that the jurisdictional bar in Section 405(h) was inapplicable to challenges that are "procedural" in nature. To the contrary, the Court made clear in *Mathews* v. *Eldridge*, 424 U.S. 319, 327 (1976), that Section 405(h) barred federal question jurisdiction over the challenge in that case to the procedures used to terminate disability benefits. See *Ringer*, slip op. 11; *Ellis* v. *Blum*, 643 F.2d 68, 77-78 (2d Cir. 1981). See also *Califano* v. *Yamasaki*, 442 U.S. 682, 697-698 (1979).

b. There is no need to consider further the plausibility of the court of appeals' efforts in its first opinion to avoid Section 405(h) and *Salfi*, because this Court's subsequent decision in *Ringer* explicitly rejected the views advanced by the court of appeals in that opinion.

In *Ringer*, the Court held that Section 405(h) barred the bringing of an action under 28 U.S.C. 1331 to challenge instructions and a formal ruling issued by the Secretary. Slip op. 10-12, 16-23. The Ninth Circuit in *Ringer*, like the Sixth Circuit in this case, had held that the plaintiffs' challenge to the instructions and ruling was "procedural" in nature and therefore was not barred by Section 405(h). This Court, however, explicitly "disagree[d] with

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282, 287 (7th Cir. 1983); *V.N.A. of Greater Tift County, Inc.* v. *Heckler*, 711 F.2d 1020, 1024-1027 (11th Cir. 1983), cert. denied, 466 U.S. 936 (1984); *Hadley Memorial Hospital, Inc.* v. *Schweiker*, 689 F.2d 905, 908-910 (10th Cir. 1982); *Humana of South Carolina, Inc.* v. *Califano*, 590 F.2d 1070, 1074-1076, 1079 (D.C. Cir. 1978); *Rhode Island Hospital* v. *Califano*, 585 F.2d 1153, 1158 (1st Cir. 1978); *Dr. John T. MacDonald Foundation, Inc.* v. *Califano*, 571 F.2d 328, 331-332 (5th Cir.) (en banc), cert. denied, 439 U.S. 893 (1978).

the Court of Appeals' separation of the particular claims * * * into 'substantive' and 'procedural' elements" and "disagree[d] in particular with its apparent conclusion that simply because a claim somehow can be construed as 'procedural,' it is cognizable in federal district court by way of federal question jurisdiction." *Ringer*, slip op. 11. The Court held that "to be true to the language of the statute, the inquiry in determining whether § 405(h) bars federal question jurisdiction must be whether the claim 'arises under' the Act, not whether it lends itself to a 'substantive' rather than a 'procedural' label." Slip op. 11. There can be no question in this case that respondents' claim that the Secretary's regulation violates the Social Security Act is a claim "arising under" that Act, irrespective of the "procedural" label respondents attach to their argument.

Ringer likewise rejected the court of appeals' notion that Section 405(h) does not apply where, as here, the plaintiffs do not seek an actual award of benefits or seek review of an administrative decision on a particular claim. The Court explicitly held in *Ringer* that "[i]t is of no importance that respondents here, unlike the claimants in *Weinberger* v. *Salfi*, *supra*, sought only declaratory and injunctive relief and not an actual award of benefits as well." Slip op. 12. Relying on *Salfi*, the Court held that federal question jurisdiction was barred by Section 405(h) because the source for " 'both the standing and the substantive basis for the presentation' of the claims was the Social Security Act" (slip op. 11-12, quoting *Salfi*, 422 U.S. at 760-761). Respondents' claims in this case clearly are barred under this "broad test" of the reach of Section 405(h) (*Ringer*, slip op. 12).

The court of appeals also sought in its first opinion to distinguish *Salfi* and its progeny on the ground that judicial review was in any event available in those cases under 42 U.S.C. 405(g). The court of appeals reasoned that if Section 405(h) were read to bar federal question jurisdiction under the Part B Medicare Program, judicial review would be entirely foreclosed, because 42 U.S.C. 405(g) is not available as an alternative avenue for judicial review under Part B. The court was unwilling to give that effect to Section 405(h). See Pet. App. 10a. Thereafter, however, this Court in *Ringer* explicitly rejected the proposition that the meaning of Section 405(h) somehow shifts depending on whether review is available under Section 405(g). *Ringer*, slip op. 19.

c. Following this Court's remand of the instant case for further consideration in light of *Ringer*, the court of appeals recited most of the controlling aspects of *Ringer* just discussed (Pet. App. 19a-20a). But in a single paragraph and without elaboration, the court of appeals nevertheless reinstated its prior opinion finding jurisdiction under 28 U.S.C. 1331 (Pet. App. 22a). This holding regarding the scope of Section 405(h) obviously cannot stand in light of *Ringer*.

In contrast to the decision below, other courts of appeals have recognized that, in light of *Ringer*, Section 405(h) removes jurisdiction under 28 U.S.C. 1331 in a case such as this. See *Hatcher* v. *Heckler*, 772 F.2d at 430-432; *American Federation of Home Health Agencies, Inc.* v. *Heckler*, 754 F.2d 896, 897-898 (11th Cir. 1984); *Ganem* v. *Heckler*, 746 F.2d 844, 848 (D.C. Cir. 1984); *Smith* v. *North Louisiana Medical Review Ass'n*, 735 F.2d 168, 171-172 (5th Cir. 1984). Indeed, the Sixth Circuit itself recently recognized in a Part A Medicare case that Section

405(h) bars jurisdiction under 28 U.S.C. 1331 over a suit challenging the method by which reimbursement is determined. *Good Samaritan Medical Center* v. *Secretary of Health & Human Services*, No. 84-3923 (Nov. 7, 1985), slip op. 5-7. The court distinguished its holding in the instant case on the ground —explicitly rejected in *Ringer*—that there is an "implied exception" to Section 405(h) where (as under Part B) the Social Security Act itself does not provide for judicial review. Slip op. 7.

B. The Jurisdictional Bar In 42 U.S.C. 405(h) Applies To Suits By Physicians As Well As Suits By Part B Beneficiaries

The court of appeals also held on remand that *Ringer* does not bar a judicial challenge "by a party other than a claimant for benefits" (Pet. App. 22a). Although the court did not explain to whom it was referring in the quoted phrase, it apparently meant anyone who had not yet submitted an actual claim for Part B benefits, or at least any of the respondent physicians who had not done so. This attempt to distinguish *Ringer* is frivolous.

In *Ringer*, one of the Part B beneficiaries had not yet had the BCBR surgery and thus was not in a position to submit a claim for benefits. The Court nevertheless held that 42 U.S.C. 405(h) foreclosed the beneficiary from bringing an action under 28 U.S.C. 1331 to challenge the Secretary's ruling that barred payment for the surgery. Slip op. 16-23. Any respondent in this case who has not submitted a Part B claim is in precisely the same position as that plaintiff in *Ringer*, and his suit under 28 U.S.C. 1331 therefore is equally barred by 42 U.S.C. 405(h).

Moreover, because it is the beneficiaries who pay premiums to be insured under the Part B Program

and who therefore are most directly affected by regulations limiting the amount of benefits, it would be quite anomalous for Congress to permit physicians to obtain judicial review but to deny such review to beneficiaries. The Act itself demonstrates that Congress did no such thing. The carrier may make payment to a physician only if the beneficiary has assigned his claim to the physician. 42 U.S.C. 1395u (b)(3)(B)(ii). The latter's interest in the determination of a Part B claim therefore is entirely derivative of that of the beneficiary. In recognition of this fact, the Secretary by regulation has provided that a physician who accepts an assignment stands in the shoes of the beneficiary and has the same right to administrative review by the carrier. 42 C.F.R. 405.801(a); *Erika*, 456 U.S. at 207 n.7. But the assignee also is subject to the same preclusion of *judicial* review that applies to the beneficiary. The Court so held in *Erika*. There it was the supplier of services, not the beneficiaries themselves, who sought judicial review (456 U.S. at 204), but the Court held that such review was barred.

This foreclosure of review under Part B is confirmed by a comparison with the Part A Program. Congress enacted a separate mechanism by which a hospital or other Part A provider may obtain judicial review of the amount of reimbursement it will receive for services rendered to Medicare beneficiaries. 42 U.S.C. 1395*oo*(f); see pages 3-4, *supra*. "In the context of the statute's precisely drawn provisions," the fact that Congress expressly provided for judicial review for providers under Part A, but not for their counterparts under Part B, furnishes persuasive evidence that Congress "deliberately intended to foreclose" judicial review under Part B in suits brought

by physicians. *Erika*, 456 U.S. at 208. See also *Block* v. *Community Nutrition Institute*, slip op. 6.

III. THE DISTRICT COURT'S EXERCISE OF JURISDICTION IN THIS CASE CANNOT BE SUPPORTED BY A PRESUMPTION IN FAVOR OF JUDICIAL REVIEW

In finding that the district court had jurisdiction in this case, the court of appeals in the end was forced to rely on nothing more than a "presumption" in favor of judicial review, believing that "for every right there must be a remedy" (Pet. App. 20a). But this Court made clear in *Block* v. *Community Nutrition Institute, supra*, that "[t]he presumption favoring judicial review of administrative action is just that—a presumption" (slip op. 8)—and that it may be overcome by a consideration of the language, structure, purpose and legislative history of the statute and the nature of the administrative action involved (slip op. 5, 8-11). When the court of appeals first ruled, this Court already had held in *Erika* that a congressional intent to preclude judicial review under Part B was "persuasive[ly] evidence[d]" by the text of 42 U.S.C. 1395ff and "unambiguously support[ed]" by its legislative history (456 U.S. at 208, 211). Subsequently, the Court, without dissent, adhered to that view in *Ringer* (slip op. 5 n.4). These holdings should have been sufficient for the court of appeals, on remand after *Ringer*, to overcome any presumption in favor of judicial review.

In an effort to establish a jurisdictional toehold, respondents also insist (Br. in Opp. 11-19) that this case presents the question whether Congress has foreclosed judicial consideration of constitutional questions arising in connection with the Medicare Pro-

gram. In their view, there must be a presumption that Congress has not done so, even in the face of the sweeping and cumulative preclusions of review in 42 U.S.C. 1395ff and 405(h). See Br. in Opp. 12-13, 19. From this premise, respondents argue that the court of appeals was correct in finding jurisdiction over *all* aspects of this suit, statutory as well as constitutional. This argument is seriously flawed.

As we have demonstrated in Points I and II, Congress has deliberately and unambiguously foreclosed judicial review of all statutory, procedural, regulatory, and factual issues touching on the amount of benefits payable under the Part B Medicare Program. For this reason, even if respondents were correct that Congress has not also foreclosed challenges that are framed in constitutional terms, such a holding would not permit judicial review of the other issues the courts below reached and decided. Indeed, the district court and court of appeals expressly declined to pass on respondents' constitutional challenge to the differing charge screens. See Pet. App. 5a, 13a n.5, 27a-28a, 32a.

This Court's decision in *Schweiker* v. *McClure*, *supra*, provides no support for respondents' position. In *McClure*, the Court reviewed the merits of a constitutional challenge to the provisions of the Social Security Act that provide for carrier hearing officers, rather than ALJs in the Department of Health and Human Services, to conduct hearings on Part B claims. The Court did not address the question of the district court's jurisdiction to entertain that suit. But even if we assume that the Court in *McClure* believed that 42 U.S.C. 1395ff and 405(h) should not be construed to foreclose a judicial challenge to the constitutionality of a provision of the Social Security

Act itself (cf. *Hatcher* v. *Heckler*, 772 F.2d at 431-432 n.7; compare *Salfi*, 422 U.S. at 762; *Johnson* v. *Robison*, 415 U.S. 361, 366-367 (1974)), that assumption would not assist respondents here. Respondents do not challenge the constitutionality of any provision of the Social Security Act. They challenge only the constitutionality of one carrier's method of calculating the reasonable charge for particular services, in conformity with a regulation issued by the Secretary. *McClure*, *Salfi* and *Johnson* do not indicate that it might be unconstitutional for Congress to foreclose judicial review of constitutional objections to such administrative determinations.

There is no need to resolve that question in this case, however, because here, as in *Ringer* (slip op. 5 n.4), respondents' constitutional contentions are in any event too insubstantial to support subject matter jurisdiction. See *Hagans* v. *Lavine*, 415 U.S. 528, 536-538 (1974). A classification under an Act of Congress providing for the distribution of benefits must be sustained against an equal protection challenge unless the varying treatment of different groups is so unrelated to the achievement of a legitimate governmental purpose as to be irrational or patently arbitrary. See, *e.g.*, *Schweiker* v. *Wilson*, 450 U.S. 221, 230 (1981); *United States Railroad Retirement Board* v. *Fritz*, 449 U.S. 166, 174-177 (1980); *Flemming* v. *Nestor*, 363 U.S. 603, 611 (1960). See also *City of Cleburne* v. *Cleburne Living Center, Inc.*, No. 84-468 (July 1, 1985), slip op. 13; *Vance* v. *Bradley*, 440 U.S. 93, 97 (1979). The Part B Medicare Program was established to "provide medical insurance benefits" (42 U.S.C. 1395j) that are calculated, in general, on the basis of 80% of the "reasonable charge" for covered services (42 U.S.C. 1395*l*(a)(1)).

In determining whether a charge is "reasonable," the carrier is to refer to the prevailing charge for similar services in the community. 42 U.S.C. 1395u(b)(3).

The regulation respondents challenge implements these statutory principles. It is based on the wholly unremarkable proposition that "[t]he range of prevailing charges in the locality may be different for physicians * * * who engage in a specialty practice or service than for others," and it accordingly permits a carrier to develop more than one range of prevailing charges that reflect "[e]xisting differentials in the level of charges between different kinds of practice or service" (42 C.F.R. 405.504(b)). Because the regulation thus provides for differing charge screens based on existing differentials in charging practices, it is, beyond question, rationally related to the legitimate purpose of the Part B Program to provide insurance benefits that are based on the pattern of charges in the community. Respondents' constitutional challenge to the authorization in 42 C.F.R. 405.504(b) for the creation of separate charge screens therefore is wholly insubstantial.[12]

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[12] Respondents also argued in district court that the differing charge screens create an unconstitutional irrebuttable presumption that services rendered by family physicians are worth less than those of other physicians (J.A. 24-26). This contention is frivolous. The Act does not deem the actual "worth" of any individual physician's services to be dispositive of the question of the amount of benefits payable for those services, but then prohibit the claimant from introducing evidence on that question. The system of prevailing charge screens by definition is based on the creation of *categories* of similar services that are not dependent upon the circumstances of any particular claimant. Such a system plainly creates no unconstitutional irrebuttable presumption under this Court's decisions. See *Salfi*, 422 U.S. at 772-774; *United States* v. *Locke*, No. 83-1394 (Apr. 1, 1985), slip op. 18.

CONCLUSION

The judgment of the court of appeals should be reversed.

Respectfully submitted.

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APPENDIX

STATUTORY PROVISIONS AND REGULATIONS INVOLVED

1. 28 U.S.C. 1331 provides:

> The district courts shall have original jurisdiction of all civil actions arising under the Constitution, laws, or treaties of the United States.

2. Section 205(h) of the Social Security Act, 42 U.S.C. 405(h), provides:

> The findings and decisions of the Secretary after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the Secretary shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the Secretary, or any officer or employee thereof shall be brought under sections 1331 or 1346 of title 28 to recover on any claim arising under this subchapter.

3. Section 1842 of the Social Security Act, as codified at 42 U.S.C. 1395u, provides in pertinent part:

> (a) Authority of Secretary to enter into contracts with carriers
>
> In order to provide for the administration of the benefits under this part with maximum efficiency and convenience for individuals entitled to benefits under this part and for providers of services and other persons furnishing services to such individuals, and with a view to furthering coordination of the administration of the

benefits under part A and under this part, the Secretary is authorized to enter into contracts with carriers, including carriers with which agreements under section 1395h of this title are in effect, which will perform some or all of the following functions (or, to the extent provided in such contracts, will secure performance thereof by other organizations); and, with respect to any of the following functions which involve payments for physicians' services on a reasonable charge basis, the Secretary shall to the extent possible enter into such contracts:

(1)(A) make determinations of the rates and amounts of payments required pursuant to this part to be made to providers of services and other persons on a reasonable cost or reasonable charge basis (as may be applicable);

* * * * *

(b) Applicability of competitive bidding provisions; findings as to financial responsibility, etc., of carrier; contractual duties imposed by contract

* * * * *

(3) Each such contract shall provide that the carrier—

(A) will take such action as may be necessary to assure that, where payment under this part for a service is on a cost basis, the cost is reasonable cost (as determined under section 1395x(v) of this title;

(B) will take such action as may be necessary to assure that, where payment under this part for a service is on a charge basis, such charge will be reasonable and not

higher than the charge applicable, for a comparable service and under comparable circumstances, to the policyholders and subscribers of the carrier, and such payment will (except as otherwise provided in section 1395gg(f) of this title) be made—

(i) on the basis of an itemized bill; or

(ii) on the basis of an assignment under the terms of which (I) the reasonable charge is the full charge for the service and (II) the physician or other person furnishing such service agrees not to charge for such service if payment may not be made therefor by reason of the provisions of paragraph (1) of section 1395y(a) of this title, * * *

* * * * *

(C) will establish and maintain procedures pursuant to which an individual enrolled under this part will be granted an opportunity for a fair hearing by the carrier, in any case where the amount in controversy is $100 or more, when requests for payment under this part with respect to services furnished him are denied or are not acted upon with reasonable promptness or when the amount of such payment is in controversy;

* * * * *

(F) will take such action as may be necessary to assure that where payment under this part for a service rendered is on a charge basis, such payment shall be determined on

the basis of the charge that is determined in accordance with this section on the basis of customary and prevailing charge levels in effect at the time the service was rendered or, in the case of services rendered more than 12 months before the year (ending on June 30) in which the bill is submitted or request for payment is made, on the basis of such levels in effect for the 12-month period preceding such year;

and shall contain such other terms and conditions not inconsistent with this section as the Secretary may find necessary or appropriate. In determining the reasonable charge for services for purposes of this paragraph, there shall be taken into consideration the customary charges for similar services generally made by the physician or other person furnishing such services, as well as the prevailing charges in the locality for similar services. No charge may be determined to be reasonable in the case of bills submitted or requests for payment made under this part after December 31, 1970, if it exceeds the higher of (i) the prevailing charge recognized by the carrier and found acceptable by the Secretary for similar services in the same locality in administering this part on December 31, 1970, or (ii) the prevailing charge level that, on the basis of statistical data and methodology acceptable to the Secretary, would cover 75 percent of the customary charges made for similar services in the same locality during the last preceding calendar year elapsing prior to the start of the twelve-month period (beginning July 1 of each year) in which the service is rendered. * * *

4. Section 1869 and of the Social Security Act, 42 U.S.C. 1395ff, provides in pertinent part:

(a) Entitlement to and amount of benefits

The determination of whether an individual is entitled to benefits under part A or part B, and the determination of the amount of benefits under part A, shall be made by the Secretary in accordance with regulations prescribed by him.

(b) Appeal by individuals

(1) Any individual dissatisfied with any determination under subsection (a) of this section as to—

(A) whether he meets the conditions of section 426 or section 426a of this title, or

(B) whether he is eligible to enroll and has enrolled pursuant to the provisions of part B of this subchapter, or section 1395i-2 of this title, or section 1819, [footnote omitted] or

(C) the amount of benefits under part A (including a determination where such amount is determined to be zero)

shall be entitled to a hearing thereon by the Secretary to the same extent as is provided in section 405(b) of this title and to judicial review of the Secretary's final decision after such hearing as is provided in section 405(g) of this title.

(2) Notwithstanding the provisions of subparagraph (C) of paragraph (1) of this subsection, a hearing shall not be available to an individual by reason of such subparagraph (C) if the amount in controversy is less than $100;

nor shall judicial review be available to an individual by reason of such subparagraph (C) if the amount in controversy is less than $1,000.

5. 42 C.F.R. 405.504(b) provides:

Variation in range of prevailing charges. The range of prevailing charges in a locality may be different for physicians or other persons who engage in a specialty practice or service than for others. Existing differentials in the level of charges between different kinds of practice or service could, in some localities, lead to the development of more than one range of prevailing charges for application by the carrier in its determinations of reasonable charges. Carrier decisions in this respect should be responsive to the existing patterns of charges by physicians and other persons who render covered services, and should establish differentials in the levels of charges between different kinds of practice or service only where in accord with such patterns.

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No. 85-225

Supreme Court, U.S.
FILED
DEC 3 1985
JOSEPH F. SPANIOL, JR.
CLERK

In the Supreme Court of the United States

OCTOBER TERM, 1985

MARGARET M. HECKLER, SECRETARY OF HEALTH AND HUMAN SERVICES, ET AL., PETITIONERS

v.

MICHIGAN ACADEMY OF FAMILY PHYSICIANS, ET AL.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

JOINT APPENDIX

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PETITION FOR WRIT OF CERTIORARI FILED AUGUST 9, 1985
CERTIORARI GRANTED OCTOBER 7, 1985

651

In the Supreme Court of the United States

OCTOBER TERM, 1985

No. 85-225

MARGARET M. HECKLER, SECRETARY OF HEALTH AND HUMAN SERVICES, ET AL., PETITIONERS

v.

MICHIGAN ACADEMY OF FAMILY PHYSICIANS, ET AL.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

JOINT APPENDIX

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IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF MICHIGAN

Civil Action No. 76-72082

MICHIGAN ACADEMY OF FAMILY PHYSICIANS, ET AL.

v.

BLUE CROSS AND BLUE SHIELD OF MICHIGAN AND DAVID MATHEWS, SECRETARY OF HEALTH, EDUCATION AND WELFARE

RELEVANT DOCKET ENTRIES

Date	NR.	Proceedings
10/ 8/76	1.	Complaint, filed. – summons issued.
1/17/77	4.	ANSWER of Blue Cross and Blue Shield of Mi., only w/ special aff. defense and proof of service. Dd 1/17/77
1/18/77		Exhibit A. (attach tc #4) DD 1/18/77
4/ 1/77	5	ANSWER of HEW w/ cert. of service. DD 4/4/77
4/20/77	7.	Interr. Directed to Deft. Joseph Califano of HEW w/ proof of service. DD 4/20/77
6/30/77	10.	Deft's Motion to Dismiss w/ brief, cert. of service and notice of hrg. set for Aug. 26, 1977 @ 10:00 am. DD 7/1/77
8/30/77	14.	Supp. Interr. to Blue Cross and Blue Shield of Michigan. DD 8/30/77
9/26/77	16.	Deft's Answer to Pltf's First Set of interr. w/ attachments A-H. DD 9/27/77

10/ 5/77	17.	Request for response on motion to dismiss by Deft. HEW, all responses, reply briefs, and any supp. briefs by Dec. 5, 1977; hrg. set for Dec. 16, 1977 @ 2:30pm. DD 10/6/77
10/26/77	18.	Answers of Defendant, Blue Cross and Blue Shield of Michigan to Plaintiffs' supplemental interrogatories. DD 10/27/77.
10/26/77	19.	Defendants' Supplemental Answer to Plaintiffs' First Set of Interrogatories with attachments and certificate of service. DD 10/27/77.
11/30/77	21.	Answer by ptfs to defts' motion to dismiss with brief and proof of service. DD 12/1/77.
12/ 7/77	22.	Defts' 2nd supplemental answer to ptfs' 1st set of interrogatories attachments DD 12/7/77
12/16/77	23.	Motion to Dismiss, taken under advisement.
12/28/77	23.	MEMORANDUM OPINION that Deft. Sec's. motion to dismiss the complaint as to any party will be denied. DD 12/30/77 Churchill J.
12/28/77	24.	ORDER Denying Deft's Motion to Dismiss. DD 12/30/77 Churchill J.
3/27/78	27.	Deposition of Paul Riesel. DD 3/29/78
4/ 5/78	30.	Plaintiff's motion for production of documents with brief, exhibits and proof of service. Hearing April 21/78. DD 4/6/78.
4/21/78	33.	Depositions of Thomas M. Tierney. DD 4/24/78
4/21/78	34.	Deposition of Thomas Tierney. DD 4/24/78
4/24/78	35.	Deposition of James Barnett. DD 4/25/78
4/24/78	36.	Deposition of John Jansak. DD 4/25/78
4/21/78		Motion for production of documents granted with a protective order. DD 4/26/78

5/22/78	37.	Transcript of April 21, 1978. DD 5/23/78
6/ 7/78	38.	DEPOSITIONS of Helen Lazenby, Stanley Katz, Roger O. Egeberg, M.D. and Henry J. Hehir. DD 6/7/78
6/ 7/78	39.	DEPOSITIONS of Mildred L. Tyssowski, Lamont W. Williamson, Ann Gonzales and Stanley Katz. DD 6/7/78
6/19/78	40.	ORDER for Production of Documents and Protective Order. DD 6/22/78 Churchill J.
7/10/78	44.	Pltf's Supp. Interr. to Blue Cross and Blue Shield of Michigan w/proof of service. DD 7/12/78
8/15/78	45.	Deft. Blue Cross and Blue Shield of Michigan's Answers to Interr. w/exhibits, attached. DD 8/16/78
10/11/78	46.	Order of Re-Assignment to Judge Boyle. DD 10/13/78 Churchill J.
10/25/78	48.	Deposition of Robert Spain and Charles Hazelett, taken Aug. 22, 1978. DD 10/26/78
1/ 3/79		Status Conference Had; summary report due 3-27-79. DD 1/4/79 Cook, J.
1/25/79	55.	Deposition of Arthur D. Hamelin taken on 10-24-78. DD 1/26/79
1/25/79	56.	Deposition of Arthur J. Divak taken on 10-24-78. DD 1-26-79
1/25/79	57.	Depostition of Ronald Thomas Candelori taken on 10-23-78. DD 1-26-79
2/21/79	58.	Deposition of David Segal to be taken on 2-16-79 at 1:15 pm. DD 2-22-79
3/27/79		Status Conference had; Status Report due 5-29-79 at 4:45. Cook, J. DD 3-28-79

3/29/79	62.	Discovery Stipulation by the Parties. DD 3-29-79
4/27/79	64.	Answer to Amended Complaint DD 5-01-79
5/ 8/79	66.	Order that Pltf, Michigan Academy of Family Physicians, Charles Farber, M.D., Glenn W. House, M.D., and Lester Webb, M.D. are Granted leave to file a first amended complaint Cook, J. DD 5-11-79
5/31/79	67.	Order For Dismissal Blue Cross Blue Shield of Michigan in its private insurance capacity only without prejudice and without costs; so stipulated. Cook, J. DD 6-04-79
6/ 1/79	68.	Stip. and Order Granting Leave for Pltf to file First Amended Complaint, with First Amended Complaint attached. DD 6-04-79
6/21/79	71.	Deposition of Dennis Remington taken on 4-12-79. DD 6-22-79
6/22/79	72.	Deposition of William W. Boyles taken on 1-22-79. DD 6-25-79
6/22/79	73.	Depositions of David Siegel and Clara Thompson taken on 2-15-79 and 4-27-79. DD 6-25-79
1/15/80	77.	Stip. & Order allowing pltfs' to file second amended complaint. Cook, J. DD 1/21/80
1/15/80	78.	Pltfs' second amended complaint. DD 1/21/80
2/ 6/80	79.	Interrogatories propounded by defts' to pltfs' with proof of service DD 2/7/80
2/20/80	80.	Interrogatories to defts' with proof of service. DD 2/20/80
2/21/80	81.	Pltf's answers to interrogatories propounded by defts' to pltf's with affidavit, proof of service and attachments. DD 2/25/80

4/17/80	82.	Deposition of Ira Burney taken on 5/16/79. DD 4/17/80
4/17/80	83.	Deposition of E. Harvey Estes, Dr. M.D. taken on 12/14/79. DD 4/17/80
4/17/80	84.	Deposition of Irvin Robinson, Charles Fisher, Mahadev Mahabal and William J. Sobaski taken on 12/6/78. DD 4/17/80
4/17/80	85.	Deposition of Kenneth Kelley taken on 6/29/79. DD 4/17/80
4/17/80	86.	Deposition of George Schieber taken on 5/15/79. DD 4/17/80
4/17/80	87.	Deposition of Louis F. Hayes, M.D. taken on 11/6/78. DD 4/17/80
5/ 2/80	88.	Deft's answer to pltfs' second amended complaint
7/ 3/80	92.	Deposition of Carol A. Diedrich taken on 6/18/80. DD 7/3/80
7/10/80	93.	Order of reassignment to Judge Gilmore. Feikens, J. DD 7/28/80
9/ 2/80		Status conference held, matter set for non-jury trial on 9/11/80 at 9:00. Gilmore, J. DD 9/4/80
9/ 8/80	97.	Deposition of Robert L. Vitu, M.D. taken on 9/3/80. DD 9/8/80
9/16/80		Court continues to hear testimony, adj. to 9/17/80 at 9:00 Gilmore, J. DD 9/18/80
9/17/80		Testimony heard, trial adj. to 9/26/80 at 9:00 briefs due by 10/10/80 arguments set for 10/22/80 at 2:30. DD 9/18/80 Gilmore, J.
9/15/80		Court hears testimony in part on non-jury trial beginning today trial recessed to 9/16/80. Gilmore, J. DD 9/19/80

9/22/80	99.	Defts' motion to amend final pre-trial order to add expert witness with brief, proof of service, attachments and notice of hearing date to be set. DD 9/23/80
9/25/80	101.	Pltf's answer to defts' motion to amend final pre-trial order to add expert witness with brief and proof of service. DD 9/26/80
9/26/80		Court hears conclusion of testimony, matter set for arguments on 10/9/80 at 2:00. DD 10/1/80 Gilmore, J.
10/29/80		Final arguments heard & matter taken under advisement. Gilmore, J. DD 11/5/80
12/30/80	106.	Opinion by Judge Horace W. Gilmore that a judgment may be entered in accordance with this opinion, which shall constitute the findings of fact & conclusions of law required by FRCP 52. DD 12/31/80 Gilmore, J
1/21/81	107.	Defts' motions for rehearing and stay pending appeal with brief and proof of service. DD 1/21/81
1/22/81	108.	Pltfs' response to defts' motions for rehearing and stay pending appeal with proof of service. DD 1/23/81
1/23/81	109.	Judgment re: SEE JUDGMENT FOR ALL DETAILS. DD 1/26/81 Gilmore, J.
1/23/81		Hearing held Judgment entered. Gilmore, J. DD 1/29/81
2/23/81	111.	Order denying defts motion for rehearing & motion for stay pending appeal also denied. DD 3/10/81 Gilmore, J.
3/23/81	112.	Notice of appeal by Deft. DD 3/31/81
4/17/81	120.	Acknowledgment from CCA re: received notice of appeal on 4/3/81, Appeal case #81-1202. DD 4/21/81

1/25/82	127.	FILE with Transmittal to CCA. DD 1/25/82
2/10/82	128.	ACKNOWLEDGMENT of CCA re: receipt of file & supplemental transcripts. DD 2/11/82
7/26/82		TRANSMITTAL of supplemental transcripts (5 vol.) to CCA. DD 7/26/82
8/ 4/82	134.	CCA's Acknowledgment of receipt of supplemental transcripts. DD 8/ /82
2/11/83	135.	LETTER from dft HHS requesting attached exhibits be forwarded to CCA, with attachments. DD 2/11/83
2/11/83	136.	TRANSMITTAL with supplemental exhibits to CCA. Cert. #5297032. DD 2/11/83

IN THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

No. 81-1202

MICHIGAN ACADEMY OF FAMILY PHYSICIANS, ET AL.
PLAINTIFFS-APPELLEES

v.

BLUE CROSS AND BLUE SHIELD OF MICHIGAN AND PATRICIA HARRIS, SECRETARY OF HEALTH AND HUMAN SERVICES

RELEVANT DOCKET ENTRIES

Date		Filings – Proceedings
4/03/81	1.	Copy of notice of appeal filed; and cause docketed
1/28/82		*Certified Record* (4 vol. pleadings, 3 vol. transcript, 14 vol. depositions) filed
3/23/82	10.	Order granting appellants' motion to hold briefing in abeyance pending Supreme Court's decision in *United States v Erika, Inc.*, appellants shall file status reports at thirty (30) day intervals commencing 4/1/82.
7/30/82		*Certified Supplemental Record* (5 vol. transcript) filed
2/15/83		*Certified Supplemental Record* (1 vol. pleadings) filed
3/11/83		Joint Appendix (5) in 3 vols. (m-3/3/83)
8/29/83		Cause argued by Thomas Stuber for appellant; by Alan Gilchrist for appellee and case submitted to the Court (before: Jones, Peck, and Brown, JJ.)
2/23/84		Judgment remanding case to the Secretary for proceedings not inconsistent with this opinion (EACH PARTY TO BEAR OWN COSTS) (Jones, Peck and Brown, JJ.) F.P.

2/23/84		Opinion by Peck, J.
4/24/84	30.	Mandate issued (COSTS NONE)
7/30/84	31.	Notice of filing petition of Certiorari (Supreme Court No. 84-120) July 23, 1984.
10/ 1/84	32.	Certified copy of Supreme Court order granting petition for Writ of Certiorari; judgment vacated and case remanded to Sixth circuit for further consideration in light of *Heckler v. Ringer*
11/ 5/84	35.	Order remanding appeal to district court with instructions to dismiss (Jones, Peck and Brown, JJ.) NFP
11/15/84	36.	Petition for Rehearing (4) of appellee on 11/5/84 order (m-11/13/84)
1/28/85	40.	RESPONSE/APPELLANT: to appellee petition for rehearing (m-1/25)
2/20/85	41.	MOTION/APPELLEES: request permission to file response to appellant memorandum (m-2/14)
3/19/85	42.	PRINTED PUBLISHED ORDER granting petition for rehearing and rescinding order remanding cause to district court with instructions to dismiss; opinion of 2/23/84 is reaffirmed (Jones, Peck and Brown, JJ.)
4/01/85	43.	MOTION/APPELLANT: thirty days extension to file Petition for Rehearing EnBanc (m-3/29) (Extension to 5/2 granted; PECK, J.)
5/01/85	45.	PETITION FOR REHEARING ENBANC (m-4/30)
5/30/85	46.	ORDER: petition for rehearing en banc denied (Jones, Peck and Brown, JJ.)
6/07/85		MANDATE: issued
7/09/85	47.	MANDATE, reissued (No costs taxed)
8/20/85		SUPREME COURT NOTICE: petition for cert. filed 8/9/85 (Sup. Ct. No. 85-225)
10/23/85		SUPREME COURT ORDER: cert. granted 10/7/85
10/23/85		SERVICE OF Certified copy of Supreme Ct. ruling to Dist. Ct.

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

No. 76-72082

MICHIGAN ACADEMY OF FAMILY PHYSICIANS; CHARLES FARBER, M.D.; BLENN W. HOUSE, M.D.; AND LESTER WEBB, M.D.,
PLAINTIFFS,

v.

BLUE CROSS AND BLUE SHIELD OF MICHIGAN; AND JOSEPH CALIFANO, SECRETARY OF HEALTH, EDUCATION AND WELFARE,
DEFENDANTS.

MEMORANDUM OPINION

This complaint, filed on October 8, 1976, challenges the administration of the federal Medicare program in Michigan by Blue Cross and Blue Shield of Michigan, especially as regards the classification of family practice physicians who are board eligible but not board certified. The Secretary filed a motion to dismiss the complaint for lack of subject matter jurisdiction on June 30, 1977. Oral argument was heard on December 16, 1977, and the matter was taken under advisement.

I am most impressed with, and adopt by reference, the analysis of the jurisdictional issue in *St. Louis Univ. v. Blue Cross Hosp. Serv.*, 537 F.2d 283 (8th Cir. 1976).*

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* In arriving at the conclusion that the Eighth Circuit was correct, I am influenced by the improbability that Congress would intentionally authorize an administrative agency to delegate to a private contractor the power to violate the Constitution of the United States in the name of the United States without recourse.

Therein, in part V of its opinion, at p. 293, the court expressly declined to take a final position with respect to its jurisdiction to entertain the equal protection claim, stating:

> "Much of our jurisdictional analysis of the procedural due process issue presented in count II would seem to support our jurisdiction of count III, which also arises under the due process guaranty of the fifth amendment. If § 405(h) bars our jurisdiction, the University will have no judicial forum in which to assert its constitutional right to equal protection.
> "On the other hand, the direct purpose of this claim is to increase the amount of reimbursement to the University. Thus, it appears to fall squarely within the language of § 405(h) and of the Supreme Court in *Salfi*. 422 U.S. at 760-62, 95 S.Ct. at 2464-2465. 45 L.Ed.2d at 536-537. Additionally, count III seeks a money judgment against the United States. The doctrine of sovereign immunity probably would limit the Congress to force such an action even if based upon a constitutional violation. See *Dugan v. Rank*, 372 U.S. 609, 620, 83 S.Ct. 999, 1006, 10 L.Ed.2d 15, 23 (1983); *cf. Edelman v. Jordan*, 415 U.S. 651, 94 S.Ct. 1347, 39 L.Ed.2d 662 (1974)."

The court was concerned that the direct purpose of the asserted claim was to increase the amount of reimbursement to the university. Without doubt the plaintiffs here are motivated in part by a desire for increased payment for services, but a judicial determination that the established screens are violative of equal protection will not necessarily, and as a matter of law, have that result.

It is clear from the record that there are disputed issues of fact which may control the Court's determination with respect to the rationality of the adopted classifications.

For the foregoing reason the defendant Secretary's motion to dismiss the complaint as to any party will be denied.

JAMES P. CHURCHILL
United States District Judge

Dated: December 28, 1977

IN THE UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

Civil No. 76-72082

MICHIGAN ACADEMY OF FAMILY PHYSICIANS; CHARLES FARBER, M.D.; BLENN W. HOUSE, M.D.; AND LESTER WEBB, M.D., PLAINTIFFS

v.

BLUE CROSS AND BLUE SHIELD OF MICHIGAN; AND JOSEPH CALIFANO, SECRETARY OF HEALTH, EDUCATION AND WELFARE, DEFENDANTS.

ORDER

DENYING DEFENDANT'S MOTION TO DISMISS

At a session of said court held in the Federal Building and U.S. Courthouse, Detroit, Michigan, on December 28, 1977.

Present: HONORABLE JAMES P. CHURCHILL
United States District Judge

For the reason set forth in a Memorandum Opinion bearing this date, IT IS ORDERED that the motion to dismiss filed by the Secretary of Health, Education and Welfare, on his behalf and as agent for Blue Cross and Blue Shield of Michigan, be and hereby is DENIED.

/s/ James P. Churchill

JAMES P. CHURCHILL
United States District Judge

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

No. 6-72082

MICHIGAN ACADEMY OF FAMILY PHYSICIANS, A NON-PROFIT ASSOCIATION, CHARLES FARBER, M.D., GLENN W. HOUSE, M.D., AND LESTER WEBB, M.D., PLAINTIFFS,

v.

BLUE CROSS AND BLUE SHIELD OF MICHIGAN, AND JOSEPH CALIFANO, SECRETARY OF HEALTH, EDUCATION AND WELFARE, DEFENDANTS.

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ATTORNEY FOR PLAINTIFFS

MICHELE COLEMAN MAYES – P25058
ATTORNEY FOR DEFENDANT HEW

RALPH D. GILPIN – P26273
ATTORNEY FOR DEFENDANT BCBSM

JUDGE JULIAN A. COOK

AMENDED COMPLAINT

NOW COME the plaintiffs, Michigan Academy of Family Physicians, a Non-Profit Association, Charles Farber, M.D. and Glenn W. House, M.D. and Lester Webb, M.D., by their Attorneys, FRIMET, GOREN & BELLAMY, P.C., and for their Amended Complaint state as follows:

JURISDICTION AND PARTIES

1. Jurisdiction herein is based upon 28 U.S.C. 1343, 5 U.S.C. 701, 702, 28 U.S.C. 1331, 42 U.S.C. 405(g) and 42 U.S.C. 405(h).

2. Plaintiff, Lester Webb, M.D., is a licensed family physician in the State of Michigan, being duly licensed to engage in the practice of medicine, whose residence is in the City of Saginaw, County of Saginaw, State of Michigan. Dr. Webb is a board eligible specialist in family practice who has no assignment agreement with defendants for purposes of reimbursement.

3. That Glenn W. House, M.D., is a licensed family physician, licensed to practice medicine in the state of Michigan whose residence is in the City of Greenville, County of Montcalm, State of Michigan. Dr. House is a board certified specialist in family practice who accepts assignment for purposes of Medicare reimbursement.

4. Charles Farber, M.D., is a licensed family physician, licensed to practice medicine in the State of Michigan whose residence is in the City of Grand Rapids, County of Kent, State of Michigan. Dr. Farber is a board eligible specialist in family practice accepting assignment for purposes of Medicare reimbursement.

5. Plaintiff, Michigan Academy of Family Physicians, is a non-profit association consisting of approximately 1,500 family physicians (i.e., physicians educated and trained to develop, bring to bear and practice unique attitudes and skills which qualify him or her to provide continuing, comprehensive health maintenance medical care to the entire family, regardless of age, sex or type of problem, be it biological, behavioral, or social) throughout the state of Michigan, and whose principal place of business is in the City of Plymouth, County of Wayne, State of Michigan.

6. That the membership of the Michigan Academy of Family Physicians consists of board certified, board eligible and non-board eligible family practitioners in the state of Michigan.

7. Plaintiff, the Michigan Academy of Family Physicians, is an organization interested in alleviating the present shortage of primary care physicians and, to this end, encourages individuals entering the medical field to specialize in primary care.

8. Pursuant to statutory authority under the Social Security Act, the Secretary of Health, Education and Welfare Medicare Program. One of the regulations issued by the Secretary states that the Secretary is designated as the real party in interest in administration of the program. 33 Federal Register 11274 (Aug. 8, 1968).

9. Defendant, Joseph Califano, is a real party in interest in the administration of the Medicare Program.

10. Defendant Blue Cross and Blue Shield of Michigan (hereinafter referred to as BCBSM) is a Medical Care Corporation organized and operated under the Blue Shield Act, MCLA 550.301 et seq., and is a Hospital Care Corporation, organized and operated under the Blue Cross Act, MCLA 550.501 et seq with its principal offices at 600 Lafayette East, City of Detroit, County of Wayne, State of Michigan.

11. As a Medical and Hospital Care Corporation, defendant BCBSM offers various extensive health insurance programs to the general public. The Department of Health, Education and Welfare has designated BCBSM as the fiscal carrier under the Medicare Program for the state of Michigan.

12. That as the fiscal carrier under the Medicare Program for the state of Michigan, BCBSM processes claims submitted by physicians for services performed on behalf of Medicare recipients and generally administers the day to day operations of the Medicare Program as that program relates to the state of Michigan.

BACKGROUND FACTS

13. That in 1965 Congress enacted Title XVIII of the Social Security Act (Medicare) 42 U.S.C. 1395 et seq. This Act provides for Federal reimbursement for medical care to the aged.

14. That the Medicare Statute is divided into two distinct and separate parts; Part A involves institutional care, hospitals, nursing homes, etc., while Part B, the Program involved in this litigation, provides supplementary medical insurance benefits, primarily for physician services.

15. Under Part B of the Medicare Program, individual patients who qualify pay a premium to the Federal Government for the medical insurance benefits. The premium is generally deducted from Social Security.

16. Physicians are reimbursed for treating Medicare recipients on the basis of their "reasonable charges". Reasonable charge is the lower of the charge the physician customarily charges for the same service and the prevailing charge in the community. See 42 U.S.C. 1395u. The prevailing charge may be defined as a 75th percentile for the same service by other physicians in the same locality.

17. From the time of its inception as a hospital and medical care corporation in the state of Michigan, until the commencement of the Federal Medicare Program, defendant BCBSM, under its private health insurance program, maintained a system of payment to physicians wherein the speciality of each individual physician, or absence thereof, had no bearing whatsoever on the amount of compensation to the pysician.

18. That 42 C.F.R. 405.504 provides that the carrier *may* in establishing the prevailing fees under the procedure referred to above draw distinctions between specialists and between specialists and non-specialists *only* where such distinction are in accordance with charge patterns.

19. That BCBSM, either on its own initiative, or at the direction of defendant HEW, devised a reimbursement system in Michigan, under the Medicare Program, of three separate "screens" for purposes of determining prevailing rates for physicians. These screens include one screen for internists, whether board certified, board eligible or non-board eligible, a separate screen for "other specialists", whether board certified, board eligible or non-board eligible, and a third screen which included non-physicians (such as podiatrists and chiropractors) and family physicians.

20. This decision to segregate family physicians from all other types of physicians for purposes of determining prevailing fees under the Medicare Program in Michigan, was not supported by actual differentials in charge patterns or charge levels of any of the groups referred to above.

21. That, in fact, no study of actual charge patterns or differentials was performed comparing various groups of physicians, i.e., differences between specialists, allopathic and osteopathic physicians, etc., by either defendant HEW or defendant BCBSM.

22. The effect of defendants' arbitrary segregation of family physicians from all other physicians has been to create artifical reimbursement levels, which generally reimburse family physicians at lesser amounts than all other physicians for performing the same services on behalf of Medicare recipients. This arbitrary discrimination has gone so far as to place family physicians into a category with podiatrists and chiropractors who are not physicians and whose education and training are not comparable to those of physicians.

23. In March, 1967 an Ad Hoc Committee of Blue Shield recommended that BCBSM should terminate its fixed fee schedule as a means of reimbursing physicians under its private insurance program and adopt the same discriminatory policy it utilized in its administration of the Medicare program. This policy was formally adopted on May 19, 1967 by BCBSM's Board of Directors which revised its private insurance program to provide for the three separate screens in determining prevailing fees.

24. That BCBSM's original basis for treating family physicians differently from all other specialists, both under its private insurance capacity and under the Medicare Program, were two 1966 directives of the Michigan State Medical Society. These directives, Resolution 16 and Resolution 36, simply incorporate the language of the Medicare Statute, providing no support for "A" and Exhibit "B" attached hereto.

25. In fact, neither the Medicare regulations nor the 1966 Michigan State Medical Society directives provide any hint whatsoever that family physicians are to be segregated from all other types of physicians for Medicare reimbursement, or for any other purpose.

26. In 1972 the Michigan State Medical Society clarified its position regarding these arbitrary dual fee principles BCBSM and HEW had created. This 1972 directive provided that there be no dual fee principle between family physicians and other physicians and adopted a definition of specialist which included family physicians. See Exhibits "C" and "D" attached hereto.

27. That defendant BCBSM refused to respond to this new directive from the Michigan State Medical Society for purposes of administering both its private insurance business and the Medicare Program. See Exhibit "E" attached hereto.

28. That at or near the same time, defendant BCBSM determined that a family physician who has passed a certifying examination of the American Board of Family Practice shall be classified as a "specialist", but a Board eligible family physician or non-board eligible family physician shall be treated as a "general practitioner" for Medicare purposes and shall be paid through the third screen as referred to previously.

29. That as modified by defendant BCBSM and defendant HEW, there are currently three separate reimbursement screens under the Medicare Program, which include one screen containing board certified and board eligible internists, one screen for "other specialists", including board certified family physicians, board certified other physicians, and board eligible other physicians, and a separate screen for board eligible family physicians, non-board eligible family physicians and various non-physician groups, such as podiartrists and chiropractors.

30. This maintenance of separate reimbursement screens has the effect of treating all board certified specialists and all board eligible specialists in any specialty other than family medicine as specialists in determining reimbursement but placing board eligible family physicians and non-board family physicians in a totally different category, essentially equating family physicians who are not board certified as non-physicians.

31. Since 1969, the American Board of Family Practice has passed standards for determining qualifications in the specialty of family practice. That pursuant to these requirements, a family physician will be considered "board eligible" if that family practitioner has undertaken approved residency programs in family practice or has been practicing the specialty of family practice for a number of years. Additionally, the American Board of Family Practice requires continuing medical education on an annual basis for either board certification or board eligibility.

32. That in order to qualify for membership in the Michigan Academy of Family Physicians one must maintain continued medical education in the amount of fifty hours per year. That under these standards, plaintiffs and all members of the Michigan Academy of Family Physicians have either completed approved residency programs or have the benefit of years of experience in primary practice, coupled with continuing medical education, a requirement unique to family physicians. The education and training of family physicians is at least equal to and possibly more extensive than that of many physicians in other specialties.

33. That under the Medicare Program, a physician may either accept assignment or look to the patient for direct payments.

34. That a physician accepting assignment is a physician who agrees to charge his patients no more than the rate determined by defendants.

35. That a physician who does not accept assignment has the option of charging for his services an amount in excess of the amount paid under the Medicare Program but must turn to the individual patients for payment for these services, the individual patient subsequently receiving reimbursement from defendant in the amount allowed pursuant to the screen.

36. That effective July 30, 1978 BCBSM instituted a statewide prevailing screen, eliminating all distinctions between physician specialties for purposes of determining reasonable charges. See Exhibit "F" attached hereto.

37. That despite the elimination of specialist/generalists differentials under BCBSM's private insurance program, defendants have steadfastly refused to eliminate such distinctions for purposes of determining reasonable charges under the Medicare Program, the Medicare Program being the only major insurance program in the state of Michigan, utilizing specialist/generalist distinctions for purposes of determining reasonable charges.

COUNT I

I. VIOLATION OF PLAINTIFFS' EQUAL PROTECTION AND SUBSTANTIVE DUE PROCESS RIGHTS UNDER THE FIFTH AMENDMENT.

38. Plaintiffs incorporate Paragraphs 1 thru 37 of their Complaint as if fully set forth herein.

39. Defendant BCBSM, while acting as intermediary or carrier under the Medicare Program, either in paying reimbursement claims or in determining prevailing fees, acts under color of Federal Law, thus, subjecting that organization to the due process and equal protection provisions contained in the Fifth Amendment to the United States Constitution.

40. Joseph Califano, as Secretary of the Department of Health, Education and Welfare, must administer the Medicare Program in a rational manner in order to comply with the due process guarantees of the Fifth Amendment of the United States Constitution, which has been held to incorporate the equal protection clause contained in the Fourteenth Amendment.

41. There are three recognized levels of health care, to wit: primary, secondary and tertiary. Family physicians are primarily involved in rendering primary care and are considered specialists in providing such services.

42. The practical impact of defendants BCBSM and HEW's creation and maintenance of the aforementioned separate screens is incongruent and creates the following irrational results:

(a) Plaintiff, Glenn W. House, M.D., as a board certified specialist in family practice, receives the same level of Medicare reimbursements in performing primary care procedures under the "screens" as a board certified or board eligible specialist who has less training and experience in the area of primary care while receiving less than board certified or board eligible specialists in internal medicine, whose training and experience is most similar to his own.

(b) Physicians in other specialties, in addition to performing secondary and tertiary health care services, for which they receive greater reimbursement than for primary care services, are performing in primary care services for which Dr. Charles Farber and Dr. Lester Webb, as family physicians, have equal or greater experience and training. Despite the equal or greater training and experience of plaintiffs Charles Farber, M.D. and Lester Webb, M.D. in the area of primary care, board eligible specialists who do not specialize in primary care receive greater reimbursement for primary care procedures.

(c) While separating family physicians from all other types of physicians for purposes of determining reasonable charges, family physicians are equated with podiatrists, chiropractors and other non-physicians, even though the training and experience of these non-physicians is in no way related to the training, experience and actual charge levels of plaintiffs.

(d) Medicare recipients who choose to be treated by family physicians and who pay the same premiums to the Federal Government for Medicare coverage receive less coverage by virtue of choosing a family physician to perform services than Medicare recipients who choose physicians of other specialties. The net effect of the Medicare reimbursement scheme is a direct economic loss to Medicare recipients treated by family physicians by virtue of the recipient's choice of physician for treatment.

(e) A board certified or board eligible physician in all fields except family practice is treated as a specialist for all services performed. For example, a general surgeon performing a pelvic examination is treated identically with a gynecologist for purposes of Medicare reimbursement.

(f) The reimbursement policy of defendants in administering the Medicare Program further aggravates the present shortage of primary care physicians, such as family physicians, which Congress has already characterized as an acute shortage. (See Health Profession's Educational Assistance Act of 1976, P.L. 94-484(HR 5546); October 12, 1976). This discriminatory treatment of plaintiffs by defendants is directly contrary to defendants' self-espoused objectives of cost containment.

43. That the treatment of family physicians differently from all other types of physicians for the performance of identical services constitutes a violation by defendants of plaintiffs' Fifth Amendment rights to equal protection and substantive due process.

44. Defendant BCBSM's and HEW's unconstitutional, arbitrary and capricious acts have created artificial rate discriminations which cause family physicians to be paid at a lower amount for performing identical services as other physicians, while being paid the same amount as non-physicians, such as podiatrists and chiropractors.

WHEREFORE, plaintiffs pray that this Honorable Court declare the maintenance of separate fee schedules by defendant Blue Cross and Blue Shield of Michigan, and by defendant, Joseph Califano, Secretary of Health, Education and Welfare, in administering the Medicare Program void and in violation of plaintiffs' equal protection and substantive due process rights and enjoin defendants from treating family physicians differently from other physicians for purposes of Medicare reimbursement.

COUNT II

VIOLATION OF PLAINTIFFS' PROCEDURAL DUE PROCESS RIGHTS UNDER THE FIFTH AMENDMENT.

45. Plaintiffs hereby incorporate Paragraphs 1 thru 44 of their Complaint as if fully set forth herein.

46. That on October 9, 1974 planitiffs requested a hearing with Defendant BCBSM, acting as carrier under HEW's Medicare Program, to provide plaintiffs with an opportunity to demonstrate that plaintiffs' training and experience was such as to warrant reimbursement equal to that received by other physicians. See Exhibits "G", "H", and "I" attached hereto.

47. That on December 6, 1974 defendant BCBSM indicated that plaintiffs may utilize a peer review procedure, but defendant BCBSM stated that the peer review officer's authority did not include the authority to make an adjudication regarding the reasonableness of the special/generalist fee differential, and that BCBSM would not accept any findings that would allow plaintiffs to be reimbursed amounts in excess of that allowed pursuant to the separate screen mechanism. See Exhibit "K" attached hereto.

48. By denying plaintiffs an opportunity to demonstrate that they have sufficiently qualified as family physicians to receive reimbursement equal to that currently being provided other physicians is to deny plaintiffs a hearing and creates an irrebuttable presumption that a family physician who performs a given medical procedure does not perform as valuable a service as other physicians performing the same service.

49. That the creation of such an irrebuttable presumption, based on the irrational determination that the service provided by family physicians are worth less than identical services performed by other physicians, is in violation of plaintiffs' procedural due process rights which are guaranteed by the Fifth Amendment to the United States Constitution, which would require defendants to provide plaintiffs notice and an opportunity for hearing prior to making such a presumption.

WHEREFORE, plaintiffs pray that this Honorable Court declare the maintenance of the three separate fee schedules by defendant and by defendant Joseph Califano, Secretary of Health, Education and Welfare, under the Medicare Program, void and in violation of plaintiffs' procedural due process rights and enjoin defendants from treating family physicians differently from other physicians under the Medicare Program.

COUNT III

VIOLATION OF MEDICARE STATUTE

50. Plaintiffs incorporate Paragraphs 1 thru 49 of their Complaint as if fully set forth herein.

51. Defendants BCBSM and HEW must comply with applicable Medicare statutes when performing its functions under the Medicare Program.

52. 42 U.S.C. 1345a guarantees a free choice by Medicare recipients of a physician under the Medicare Program.

53. Although plaintiffs' patients are equally eligible for benefits as other patients under the Medicare Program, and have paid premiums equal to that of other patients, plaintiffs' patients receive less coverage under said Program solely by virtue of choosing family physicians to perform covered services than do the patients of specialists.

54. Since these patients are directly responsible to the physician in cases of non-assignment of claim, the patients of plaintiffs suffer direct economic loss by virture of their choice of physician.

55. That the treating of family physicians differently from all other types of physicians and the lumping of family physicians with non-physicians constitutes a value judgment that the services of family physicians are not as valuable to the patient as services by other physicians, this judgment having no reasonable relationship to the administration of the Medicare Program and infringing directly upon the patient's choice of physician.

56. 42 U.S.C. 1395u(3)(E) simply provides that Medicare shall establish a prevailing charge ceiling equal to 75% of charges "for similar services in the same locality."

57. That there is no statutory authority granted to defendants to draw distinctions in payment between different types of specialty practice.

58. Defendants, in treating family physicians differently from all other types of physicians, are in direct contradiction of the Medicare statute, which bases the prevailing fee concept on similarity of service rather than any particular classification of the physician where identical services are performed.

WHEREFORE, plaintiffs pray that this Honorable Court Order that the maintenance of the separate fee schedules is in violation of the Medicare Act and enjoin defendants from treating family physicians different from other physicians in the administration of the Medicare Program.

COUNT IV

VIOLATION OF REGULATIONS

60. Plaintiffs incorporate Paragraphs 1 thru 59 of this Complaint as if fully set forth herein.

61. 42 C.F.R. 405.504(b) provides that Medicare carriers may establish separate prevailing charge screens for different types of physicians *only* where in accordance with actual charge patterns.

62. That, to date, defendants have failed to produce any data or other statistical evidence in support of the maintenance of separate screens within the state of Michigan.

WHEREFORE, plaintiffs pray that this Honorable Court declare the maintenance of separate fee schedules by defendants Blue Cross and Blue Shield of Michigan and Joseph Califano, Secretary of Health, Education and Welfare, in administering the Medicare Program, void and in violation of defendants' own promulgated regulations and enjoin defendants from treating family physicians differently from other physicians for purposes of Medicare reimbursement.

/s/ CHARLES FARBER, M.D.
CHARLES Farber, M.D.

/s/ GLENN W. HOUSE, M.D.
Glenn W. House, M.D.

/s/ LESTER WEBB, M.D.
Lester Webb, M.D.

STATE OF MICHIGAN) SS
COUNTY OF)

On this 20th day of March, 1979 before me personally appeared Charles Farber, M.D., who, being by me duly sworn, did depose and say that he has read the foregoing Complaint by him subscribed, that the same is true of his own knowledge, except as to those matters stated to be upon information and belief, and as to those matters, he believes it to be true.

/s/ CAROL J. TOWNSEND
Notary Public, [Kent] County, Michigan

My comm. expires: 10/13/79

STATE OF MICHIGAN) SS
COUNTY OF)

On this 10th day of April, 1979, before me personally appeared Glenn W. House, M.D., who, being by me duly sworn, did depose and say that he has read the foregoing Amended Complaint, by him subscribed, that the same is true of his own knowledge, except as to those matters stated to be upon information and belief, and as to those matters, he believes it to be true.

/s/ DELPHINE S. LEVESON
Notary Public, Oakland County, Michigan

My comm. expires: 1-11-82

STATE OF MICHIGAN) SS
COUNTY OF)

On this 15th day of March, 1979, before me personally appeared Lester Webb, M.D., who, being by me duly sworn, did depose and say that he has read the foregoing Amended Complaint, by him subscribed, that the same is true of his own knowledge, except as to those matters stated to be upon information and belief, and as to those matters, he believes it to be true.

/s/ DENNIS R. PRICING
Notary Public, Saginaw
County, Michigan

My comm. expires: [Illegible]

FRIMET, GOREN & BELLAMY, P.C.

By /S/ ALAN G. GILCHRIST
ALAN G. GILCHRIST
Attorneys for Plaintiffs
26600 Telegraph Road, Ste 310
Southfield, MI 48034
355-0022

Dated:

Exhibit A to the Amended Complaint

Resolution No. 16 of the House of Delegates of the Michigan State Medical Society (1966).

Definition of Customary, Prevailing and Reasonable Fee Introduced by George Reno, MD

Whereas, the Department of Health, Education and Welfare has accepted the concept of "customary, prevailing and reasonable fees" to physicians under Public Law 89-97, and

Whereas, these terms are not defined in the law, and

Whereas, the American Medical Association House of Delegates has deferred action on the matter until its Clinical Session in November, and

Whereas, the membership needs immediate guidance in the interpretation of these terms in billing for services under Public Law 89-97, therefore be it

RESOLVED: That the House of Delegates of the Michigan State Medical Society hereby adopt the following definitions as approved in principle by the American Medical Association House of Delegates:

Customary relates to the individual physician and the charge which he most commonly establishes as fair recompense for specific services.

Prevailing relates to the range of usual charges made by physicians of similar ability and experience for the same service within the same specific socio-economic limited geographic area.

Reasonable: A fee is "reasonable" when it meets the "customary and prevailing" criteria or, in the opinion of a duly constituted medical society review committee, is justified under what is considered a complexity of treatment which merits special consideration, and be it be forwarded to Michigan Medical Service as fiscal agent of the Medicare program in Michigan.

THE REFERENCE COMMITTEE on Resolutions, Harold F. Falls, MD, Chairman, recommended approval of the resolution, amending the first Resolved to read as follows: "RESOLVED: That the House of Delegates of the MSMS hereby adopts the following definitions:
CUSTOMARY relates to the individual physician and the charge which he most commonly establishes as fair compensate for specific services.
PREVAILING relates to the range of usual charges made by physicians of similar ability and experience for the same service within the same specific socio-economic limited geographic area.
REASONABLE: A fee is "reasonable" when it meets the "customary and prevailing" criteria or, in the opinion of a duly constituted medical society committee, is justified under what is considered a complexity of treatment which merits special consideration, and be it further"

The HOUSE adopted the report of the Reference Committee.

Exhibit B to the Amended Complaint

Resolution No. 34 of the House of Delegates of the Michigan State Medical Society (1966).

Enactment of a Single Medical Practice Law
Introduced by John H. McLaughlin, MD

Whereas, the primary concern of Michigan doctors of medicine is the health needs of the people of Michigan, and

Whereas, this likewise is the primary concern of doctors of osteopathy, and

Whereas, the basic tenets of these two disciplines are essentially identical, and

Whereas, the present duplication of systems reduces the opportunity for attaining maximum standards of achievement in education, in research and ultimately in the care of the patient, therefore be it

RESOLVED: That the House of Delegates reaffirm its endorsement of a single medical practice act, and be it further

RESOLVED: That the Michigan State Medical Society promote legislation toward enactment of a single medical practice act.

THE REFERENCE COMMITTEE on Legislation and Public Relations, Philip K. Stevens, MD, Chairman, considered Resolutions 18 and 34 together.

For Reference Committee and House action, see Resolution 18.

Exhibit C to the Amended Complaint

Policy Statements of the Council of Michigan State Medical Society

Physician's fees

From 1965 to 1968 the MSMS Council made the following policy statements re Physician Fees:

* * * * *

The Council reaffirmed existing MSMS policy that there be no dual fee principle (between specialists and generalists) and that all reimbursements for service remain on a fee-for-service basis.
Council 66Apr/p46/3.

* * * * *

Exhibit D to the Amended Complaint

Policy Statement of the Michigan State Medical Society

SPECIALIST

Definition

MSMS has approved the following definition of a specialist:

"A specialist shall be a physician

1. certified by the appropriate specialty board, approved by the American Board for Medical Specialties and by the American Medical Association Council on Medical Education, or

2. practicing as a specialist not possessing a specialty board certificate, but has completed an approved residency in that specialty, or

3. is recognized as a specialist by the staff of the hospital in which he practices provided it is an accredited hospital, and is a physician who is eligible for certification by his specialty board."

Resolution No. 38 of the House of Delegates (1971).

Exhibit E to the Amended Complaint

Memorandum

For Information Only.

From February 9, 1972 minutes of
Consumer and Professional Relations
Committee of the Board of Directors.
[Blue Shield of Michigan]

IV. Definition of a Specialist:
Doctor Hayes described the background of this subject and the Committee was asked whether Blue Shield should adopt the 1971 MSMS House of Delegates Resolution #38, Definition of a Specialist, or an alternate definition proposed by management.

Discussion occurred regarding payments to different specialties, specialty Board eligibility and examinations, the new American Board of Family Practice, and the implications to Blue Shield of adopting either proposed change for MVF and Government Programs.

It was the consensus of the Committee that "specialists," in the traditional sense, should receive a higher level of payment than a specialist in Family Practice because there is a higher degree of training and skill in the traditional specialties.

MOTION was made, seconded and carried to recommend to the Board that Blue Shield retain the present definition of a specialist as adopted by the 1966 MSMS House of Delegates, with the understanding that management should study the feasibility of establishing a separate prevailing charge screen for the new specialty of Family Practice.

Exhibit F to the Amended Complaint

BLUE CROSS AND BLUE SHIELD OF MICHIGAN

JULY 26, 1978

GENERAL MEMO

Cancellation Date: September 26, 1978

TO: Supervisors and Above

SUBJECT: Statewide Prevailing Screens

Effective July 30, 1978 a statewide prevailing screen has been approved for payment of claims from all physicians by the Board of Directors of Blue Cross and Blue Shield of Michigan.

Since January of this year a statewide screen has been effective for participating physicians only. These physicians have been paid the lessor of the billed charge, the customary profile charge or the statewide prevailing screen. The non-participating physicians have been subject to the area/specialty prevailing screens.

The move to a statewide screen is the result of an agreement between Blue Cross and Blue Shield of Michigan and the Michigan State Medical Society. MSMS agreed to urge physicians to cooperate on the completion of the Michigan Medical Claim Form and to discontinue its efforts to seek physician departicipation. In return BCBSM is establishing a statewide screen for all physicians types in the state.

In addition to these points, all parties have selected representatives for a liaison committee to discuss the establishment of a prospective system to control aggregate payments for professional health care services and the development of an effective full service benefit by January 1, 1979. The effective date of the statewide screen for all physicians was contingent upon the agreement by the liaison committee of a plan of action and a timetable for implementation of the prospective reimbursement and the full service benefit. Details of both will be worked out in the next few months.

Any adjudication of claims priced prior to July 30 should continue to employ the area/specialty screens for non-par providers. The statewide screen is effective for claims priced beginning July 30, 1978.

Daniel J. Kehoe
Vice President
Provider Affairs

Exhibit G to the Amended Complaint

October 9, 1974

Mr. John McCabe, President
Michigan Medical Service
600 Lafayette East
Detroit, Michigan 48226

Re: Fee Discrimination

Dear Sir,

As a participating family physician with Michigan Medical Service, I do hereby request a hearing in order that Michigan Medical Service may present evidence and show cause why the charges Michigan Medical Service will pay me for my services as a physician are reasonable and non-discriminatory and to disclose the basis and criteria used by Michigan Medical Service to arrive at the payments made. It is my position that the fee schedules utilized by Michigan Medical Service are discriminatory towards me as a family physician. Since I believe Michigan Medical Service, as of this date, has no procedure for providing such a hearing, I suggest that the following are requisites for any such hearing:

1. That the hearing officer be a person independent of Michigan Medical Service.

2. That a written transcript be made of the hearing.

3. That the hearing officer be required to make written findings of fact and conclusions of law and that his decision be based solely on the record made by the parties before him.

4. That the petitioner be represented by counsel if he chooses.

5. That the petitioner's counsel be allowed to present written or oral evidence, cross-examine, witnesses, present oral or written argument, and in any other way represent his client and his client's interests before the hearing officer.

Mr. John McCable
October 9, 1974
Page #2

6. That the hearing officer should not be bound by formal rules of evidence.

7. That the hearing officer be furnished with no information regarding this matter by either party except when such material is simultaneously made available to the opposite party.

8. That the hearing should be open to the public and that said hearing be conducted in accordance with due process of law.

9. That the discovery, in the form of depositions, interrogatories, and requests for production of documents, be available prior to the hearing to me or my counsel with particular emphasis on the basis in which Michigan Medical Service determines the reasonable and customary charge for an individual physician.

If procedures for such a hearing already exist, please so advise me and indicate what the procedures are.

Your prompt reply would be much appreciated. Thank you.

Very truly yours,
/s/ CHARLES FARBER, M.D.

Charles Farber, M.D.

Exhibit H to the Amended Complaint

October 9, 1974

Mr. John McCabe, President
Michigan Medical Service
600 Lafayette East
Detroit, Michigan 48226

Re: Fee Discrimination

Dear Sir,

As a participating family physician with Michigan Medical Service, I do hereby request a hearing in order that Michigan Medical Service may present evidence and show cause why the charges Michigan Medical Service will pay me for my services as a physician are reasonable and non-discriminatory and to disclose the basis and criteria used by Michigan Medical Service to arrive at the payments made. It is my position that the fee schedules utilized by Michigan Medical Service are discriminatory towards me as a family physician. Since I believe Michigan Medical Service, as of this date, has no procedure for providing such a hearing, I suggest that the following are requisites for any such hearing:

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3. That the hearing officer be required to make written findings of fact and conclusions of law and that his decision be based solely on the record made by the parties before him.
4. That the petitioner be represented by counsel if he chooses.

5. That the petitioner's counsel be allowed to present written or oral evidence, cross-examine, witnesses, present oral or written argument, and in any other way represent his client and his client's interests before the hearing officer.

6. The the hearing officer should not be bound by formal rules of evidence.

7. That the hearing officer shall be furnished with no information regarding this matter by either party except when such material is simultaneously made available to the opposite party.

8. That the hearing should be open to the public and that said hearing be conducted in accordance with due process of law.

9. That the discovery, in the form of depositions, interrogatories, and requests for production of documents, be available prior to the hearing to me or my counsel with particular emphasis on the basis in which Michigan Medical Service determines the reasonable and customary charge for an individual physician.

If procedures for such a hearing already exist, please so advise me and indicate what the procedures are.

Your prompt reply would be much appreciated. Thank you.

Very truly yours,
/s/ LESTER WEBB, M.D.
Lester Webb, M.D.

Exhibit I to the Amended Complaint

October 9, 1974

Mr. John McCabe, President
Michigan Medical Service
600 Lafayette East
Detroit, Michigan

Re: Fee Discrimination

Dear Sir,

As a participating family physician with Michigan Medical Service, I do hereby request a hearing in order that Michigan Medical Service may present evidence and show cause why the charges Michigan Medical Service will pay me for my services as a physician are reasonable and non-discriminatory and to disclose the basis and criteria used by Michigan Medical Service to arrive at the payments made. It is my position that the fee schedules utilized by Michigan Medical Service are discriminatory towards me as a family physician. Since I believe Michigan Medical Service, as of this date, has no procedure for providing such a hearing, I suggest that the following are requisites for any such hearing:

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2. That a written transcript be made of the hearing.

3. That the hearing officer be required to make written findings of fact and conclusions of law and that his decision be based solely on the record made by the parties before him.

4. That the petitioner be represented by counsel if he chooses.

5. That the petitoner's counsel be allowed to present written or oral evidence, cross-examine witnesses, present oral or written argument, and in any other way represent his client and his client's interests before the hearing officer.

6. That the hearing officer should not be bound by formal rules of evidence.

7. That the hearing officer shall be furnished with no information regarding this matter by either party except when such material is simultaneously made available to the opposite party.

8. That the hearing should be open to the public and that said hearing be conducted in accordance with due process of law.

9. That the discovery, in the form of depositions, interrogatories, and requests for production of documents, be available prior to the hearing to me or my counsel with particular emphasis on the basis in which Michigan Medical Service determines the reasonable and customary charge for an individual physician.

If procedures for such a hearing already exist, please so advise me and indicate what the procedures are.

Your prompt reply would be much appreciated. Thank you.

Very truly yours,
/s/ GLENN W. HOUSE, M.D.
Glenn W. House, M.D.

Exhibit K to the Amended Complaint

Blue Shield
of Michigan

Vice President –
Assistant to the President

600 Lafayette East
Detroit, Michigan 48226

December 6, 1974

Gilbert M. Frimet, Esq.
Frimet, Goren & Bellamy P.C.
26600 Telegraph Road - Suite 310
Southfield, Michigan 48076

Dear Mr. Frimet:

This is to acknowledge your letters of October 14 and November 27 concerning Dr House, October 18 and November 27 concerning Dr. Farber, and October 28 concerning Dr. Webb.

I am advised by Louis F. Hayes, M.D., our Senior Vice President for Medical Affairs, and Henry H. Sills, Esq., our General Counsel, that in addition to representing the above referenced individual physicians you are, or have been, the attorney for the Academy of Family Physicians and that there have been extensive discussions along the lines you now request.

I am also advised by Counsel that the appropriate forum, in which to present evidence or to show cause upon a physician's demand or request in such a matter is a proper Peer Review proceeding, to which this corporation is committed, or in litigation to which it may be subjected.

Rest assured, if you or any of your clients named above wish to discuss any problem they are encountering, you are welcome to do so at any time with our Medical Affairs Division, operation of which is Dr. Hayes' responsibility. Our personnel will do whatever they can to clear up any misunderstandings you or your clients may entertain.

Very truly yours,
/s/ BRIAN P. MACRAE
Brian P. MacRae

Blue Cross
Blue Shield
of Michigan

600 Lafayette East
Detroit, Michigan 48226

March 31, 1975

Mr. Gilbert M. Frimet, Esq.
Frimet, Goren & Bellamy, P.C.
26600 Telegraph Road, Suite 310
Southfield, Michigan 48076

Dear Mr. Frimet:

Thank you for your letter of March 19, 1975, with further inquiry on the matter of peer review for fee adjudication.

It is my impression that my February 13 letter did answer your question regarding representation by counsel at peer review hearings. Questions G, H and I, all dealing with the appearance of counsel, the rules of evidence and courtroom procedure (including cross-examination), were answered. The essence of the answer was that the presence of counsel, etc., was dependent upon the rules of each peer review committee. It would be appropriate for you to query each of the existing peer review committees about their rules.

Your March 19 letter has a misunderstanding about the test that we apply in the determination of a reasonable fee for a service. In the absence of unusual circumstances (individual consideration), we have but two "rules":

1. The payment will be no higher than the physician's customary charge for the service.

2. The payment will be no higher than the prevailing charge for similar services—by physicians of similar qualification—in the same socio-economic area.

I may have a misunderstanding as to what you meant by "discovery." When we submit claims to peer review committees for fee adjudication, we provide them with pertinent data regarding the range of charges for the service in question and the applicable area and specialist/generalist [illegible].

With regard to the "authority of peer review officers to resolve the controversy," I can only say that Blue Cross-Blue Shield of Michigan is committed to accept the peer review committee's adjudication on a disputed fee. In general, it is our perception that the physicians also abide by their adjudication. However, adjudications are to be provided within the framework of our payment mechanism, which is inclusive of area and specialist/generalist differentials. We would not accept an adjudication from a peer review committee that there should be no specialist/generalist differentials.

I remain,

Sincerely,
/s/ LOUIS F. HAYES, M.D.

Louis F. Hayes, M.D.
Group Vice President
Professional Affairs Division
Blue Cross and Blue Shield of Michigan

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

[Filed April 27, 1979]

No. 76-72082

MICHIGAN ACADEMY OF FAMILY PHYSICIANS; A NON-PROFIT ASSOCIATION, CHARLES FARBER, M.D.; GLENN W. HOUSE,M.D., AND LESTER WEBB, M.D.,
PLAINTIFFS

v.

BLUE CROSS AND BLUE SHIELD OF MICHIGAN AND JOSEPH CALIFANO, SECRETARY OF HEALTH, EDUCATION AND WELFARE,
DEFENDANTS.

JUDGE JULIAN COOK

ANSWER TO AMENDED COMPLAINT

NOW COMES the defendant JOSEPH CALIFANO, Secretary of Health, Education and Welfare, through his attorneys James K. Robinson, United States Attorney, and Samuel J. Behringer, Jr., Assistant United States Attorney, both for the Eastern District of Michigan. And comes defendant BLUE CROSS AND BLUE SHIELD OF MICHIGAN in its capacity as agent only for the Department of Health, Education and Welfare, through its attorney Ralph D. Gilpin. And in answer to the allegations of the plaintiffs' Amended Complaint states as follows:

FIRST DEFENSE

The Amended Complaint fails to state a claim upon which relief can be granted.

SECOND DEFENSE

The Court lacks jurisdiction over the subject matter of Count IX of this action.

THIRD DEFENSE

Answering specifically the numbered paragraphs of the plaintiffs' Amended Complaint, and utilizing the same paragraph numbering, the defendants state as follows:

1. Admits.

2-6. Admits on information and belief.

7. Defendants are without knowledge or information sufficient to form a belief as to the allegation.

8-9. Admits.

10. Admits.

11. Admits the allegations but denies the characterization of a "health insurer" and says the statutes cited in ¶ 10 designates BCBSM as a hospital, medical, surgical non-profit pre-paid plan.

12. Admits the allegations but denies the characterization of patients as "recipients" and says they are Social Security Act Beneficiaries.

13-15. Admits.

16. Denies the allegation as stated because it is inaccurate and incomplete. Further an essential element is missing, answered in ¶ 33, below.

17. Admits.

18. Denies the allegation as phrased because the context is altered. The correct citation of 42 CFR 405.504(b) carries a different connotation.

19. Admits the allegations but says they create an incomplete picture. Internists' screens are restricted to certain inpatient services only and the third screen described includes general practitioner physicians as well.

20. Denies on information and belief.

21. Admits but adds that accumulation of charge histories accomplished the purpose.

22. Denies the allegations as phrased. The paragraph omits mention of general practitioner physicians and declares podiatrists to be non-physicians. Podiatrists are physicians and surgeons within the meaning and scope of their licensure (OAG Mich 1961-62 No 4014) and therefore are physicians and surgeons within the meaning of § 1861(r) of Title 18 of the Medicare Act as interpreted by the Secretary.

23. Admits.

24. Admits the allegations but denies the characterization of "directives". By their terms, plaintiffs' Exhibits A and B are resolutions not binding as directives on BCBSM.

25. Denies because family physicians, as a distinctive group, did not exist as a specialty in 1966.

26. Denies the validity of plaintiffs' Exhibit C which is undated and untitled, and of the allegation it purports to support. Denies that Exhibit D makes any mention of family physicians.

27. Denies that BCBSM received any "directive" from the said Medical Society and says plaintiffs' Exhibit E speaks for itself.

28. Admits and says support is found in plaintiffs' Exhibit E. Further plaintiffs' reference to general practitioner conflicts with his allegation in ¶¶ 19 and 22.

29. Admits but incorporates defendants' answers to ¶¶ 19 and 22 here also.

30. Admits the general issue of ¶ 30 but denies that family physicians are "essentially equated" to non-physicians, because it is untrue.

31-32. Defendants are without knowledge or information sufficient to form a belief but notes that the former name of the Board was the American Association of General Practitioners.

33. Admits and says that assignment of right to payment is an essential element that does not enlarge physicians rights but only conveys whatever beneficiary right that may exist. It is in the nature of a quit-claim.

34. Admits and says that the restriction referred to is unseverable from the right to payment assignment.

35. Admits and says that a physician refusal to accept, or a beneficiary's refusal to grant, assignment estops the physician from assuming any standing to complain about the administration of the Medicare Act.

36. Admits but says it was a unilateral act applying to BCBSM private sector business only having no affect upon the Medicare program.

37.Admits the general issue of ¶ 37 but says that, on information and belief, Title 19 of the Social Security Act (Medicaid) also maintains dual screens on the same basis as Medicare, it being a major health insurance program in the state of Michigan.

COUNT I

38. No answer required.

39. Admits.

40. Admits the program must be administered in a rational manner but says constitutional construction does not hold that the Fifth Amendment incorporates the due process of the Fourteenth, the latter being binding on the several states.

41. Defendants are without sufficient information to make answer to the unsupported statement in ¶ 41.

42(a) Denies the allegation as a statement of fact. The situation alleged occurs only occasionally and the reverse may also occur on occasion depending upon the particular patient care factors involved.

42(b) Defendants are without information to know whether Drs. Farber and Webb are of "greater training or experience" than all other unnamed physicians, but believes it untrue and therefore denies. Further, Dr. Webb, by his own averment in ¶ 2, is not an assignee of any Medicare beneficiary and therefore has no standing to complain about reimbursement methodology.

42(c) Defendants deny the allegations because plaintiffs are not equated with non-physicians: podiatrists and chiropractors do not render family physician services and family physicians do not perform podiatry or chiropractic. Family physicians who are *not* board certified, are equated to general practitioner physicians, both M.D. and D.O. Otherwise, they are classed as specialists with all other specialists including internists.

42(d) Defendants deny the effect of the allegation pled: (1) Medicare beneficiaries do not all pay the same premium for their Title 18 coverage (§ 1839(d) of Title 18). (2) Physicians have no standing to complain as to the beneficiary's (not recipient's) choice of practitioner. That election runs to the beneficiary exclusively and is guaranteed by § 1802 of Title 10 of the Social Security Act (42 USC 1395a).

42(e) Admits but says plaintiffs' example is misleading. A gynecologist is often a surgeon and performs as such.

42(f) Defendants are without sufficient information to answer ¶ 42(f) and leaves plaintiff to his proofs.

43. Denies on the basis that plaintiffs have no contract with or membership in, Medicare and have no standing to complain except as they individually have accepted an affirmatively tendered assignment of benefits on an individual claim from an individual beneficiary. The plaintiff physicians stand in the shoes of the beneficiary and

the concomitant right to payment is no greater because of it. Further, because plaintiff DR. WEBB has not accepted any assignments he cannot complain of the reimbursement policy. And further, because plaintiff Academy performs no medical services for beneficiaries of Title 18, plaintiff Academy can receive no assignment of benefit payment and therefore has no standing to complain (see ¶ 5 of Amended Complaint).

44. Deny for the reasons stated throughout this Answer.

WHEREFORE, defendants move this court to dismiss LESTER WEBB, M.D. as a party plaintiff on the ground that he has no standing to complain on behalf of beneficiaries because he avers he accepts no assignment of benefits from beneficiaries and is not a provider with an agreement with the Secretary under § 1866 of Title 18 of the Social Security Act. Defendants further move this court to dismiss Michigan Academy of Family Physicians on the ground that it is not a provider of services or a physician within the meaning of Title 18 and provides no medical services to any beneficiary nor is eligible to receive any payment by assignment or otherwise. Defendants further ask this court to dismiss Count I as not having made out a cause of action.

COUNT II

45. No answer required.

46. Defendants deny the validity of ¶ 46 and of plaintiffs' Exhibits G, H and I. There is no basis for such a claimed hearing right under state or federal law. Further, all three exhibit-letters are identical; they make no mention of Medicare; they relate *only* to BCBSM's private sector business which is not a basis for this Amended Complaint. Exhibit H states that LESTER WEBB, M.D. is a participating physician, whereas in ¶ 56 of plaintiffs' original verified complaint, LESTER WEBB, M.D. declared he *is not* a participating physician in the private sector.

47. Admits but says plaintiffs' Exhibit K (and Exhibit J for which there is no allegation reference) discusses private sector business only and does not incorporate any reference to or interpretation of any rule or regulation of the Secretary.

48. Defendants deny the allegation of ¶ 48 and say that there is no support for application of these averments to the Medicare program. Further if any such complaint exists, plaintiffs are barred by the Federal Tort Claims Act for failure to exhaust administrative remedies (28 USC § 2401(b)). Plaintiffs' exhibit-letters are not applications for relief to a federal officer charged with administration of Medicare.

49. Defendants deny that any irrebuttable or irrational presumptions were made but in any case, the determinations complained of in this Count II have no application to the medicare program.

WHEREFORE, defendants move this court under Rule 12(c) FRCvP for judgment on the pleadings dismissing Count II. There is no federal question presented and no pendant jurisdiction on any state claim or cause of action, none having been alleged.

COUNT III

50. No answer required.

51. Admits.

52. Admits the essence of the allegation but says Title 42 of the U.S. Code does not have a § 1345a.

53. Denies that any such result obtains from the use of family physicians. "Coverage" relates to services, not payment and is found in § 1832 *et seq.* of the Act and is available to all equally (styled Scope of Benefits). Further, Medicare beneficiaries are not recipients, and do not all pay the same premium (§ 1839(d) of Title 18). Further, plaintiffs have no standing to complain as to the rights or

disabilities of any Medicare beneficiary.

54. Denies the validity of the allegation. In non-assignment claims, plaintiffs acquire no rights to Medicare benefits whatsoever. Plaintiffs' patients have chosen their physician by free will (42 USC 1395a) and any debt created between them is not a liability over to the defendants.

55. Denies the essence of the allegation. Not all family physicians are classified as non-specialists nor are they "lumped" with non-physicians. The classifying complained of was established for good and sufficient reasons. Further, the plaintiffs are not surrogates of beneficiaries and cannot be heard to complain about how patients choose physicians.

56. Admits but says the 75% referred to in § 1395u(3) cannot be described as "simply".

57. Denies. The Act provides that charges shall be reasonable and authorizes the Secretary to promulgate rules of interpretation (§ 1871 of the Act). Plaintiffs acknowledge this fact as true in ¶61 of their Amended Complaint.

58. Denies the allegation and says it is in direct conflict with ¶61 of the Amended Complaint. Defendants incorporate their answer to ¶56 herein.

WHEREFORE, defendants pray this court to find that the administration of the Medicare program is in conformance with the controlling statutes and regulations. Further defendants move this court under Rule 12(c) FRCvP to dismiss Michigan Academy of Family Physicians as a party plaintiff on the ground that it is not a provider of services or a physician as recognized by the Act. Further defendants move the court to find that the three plaintiff doctors are not surrogates of beneficiaries and do not have standing to complain of the manner in which beneficiaries choose physicians. Further, defendants move to dismiss DR. WEBB as a party plaintiff on the additional ground that he is not an assignee of any beneficiary's right to Medicare payment and therefore has

no standing to complain as to the method of reimbursement by his own admission in ¶2 of the Amended Complaint.

COUNT IV

60. No answer required.

61. Denies the interpretation of the cited regulation. It provides for establishment of differentials in the level of charges between physicians who engage in different specialty practices, according to charge patterns.

62. Denies. Discovery to date has disclosed data and statistics supporting different screens. Further, current Medicare reasonable charge screens, in the possession of plaintiffs, show that differences in payment levels between specialists and non-specialists are equal in a great many procedures and, in some, that for non-specialists is a higher level.

WHEREFORE, defendants pray this action be dismissed and that the court grant such other and further relief as may be appropriate. Defendants incorporate their ad damnum clause to Count I herein.

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Dated:

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

No. 6-72082

MICHIGAN ACADEMY OF FAMILY PHYSICIANS, A NON-PROFIT ASSOCIATION, CHARLES FARBER, M.D., GLENN W. HOUSE, M.D., AND LESTER WEBB, M.D., AND CAROL A. DIEDRICH,
PLAINTIFFS,

VS.

BLUE CROSS AND BLUE SHIELD OF MICHIGAN, AND PATRICIA HARRIS, SECRETARY OF HEALTH, EDUCATION AND WELFARE,
DEFENDANTS.

ALAN G. GILCHRIST – P23408
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JAMES R. LITES – P29265
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MICHELE COLEMAN MAYES – P25058
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RALPH D. GILPIN – P26273
ATTORNEY FOR DEFENDANT BCBSM

SECOND AMENDED COMPLAINT

NOW COME the plaintiffs, Michigan Academy of Family Physicians, a Non-Profit Association, Charles Farber, M.D., Glenn W. House, M.D., Lester Webb, M.D., and Carol A. Diedrich, by their Attorneys, FRIMET, BELLAMY, GILCHRIST & JEHLE, P.C., and for their Second Amended Complaint state as follows:

37a. Plaintiffs hereby incorporate paragraphs 1 through 63 of their Amended Complaint as if those paragraphs were fully set forth herein.

37b. Plaintiff Carol A. Diedrich is a resident of the City of Okemos, State of Michigan and is a Medicare recipient.

37c. Plaintiff Carol A. Diedrich's physician is Phillip Lange, M.D., a family physician who is a member in good standing of the Plaintiff Michigan Academy of Family Physicians and who is not Board certified in family practice.

37d. Phillip Lange, M.D. does not accept assignment for services performed on behalf of Medicare recipients.

37e. As a result of her choice of Dr. Phillip Lange as her physician, Plaintiff Carol A. Diedrich receives less health care medical coverage under the Medicare program than similarly situated Medicare recipients who receive similar medical services even though Plaintiff Carol A. Diedrich pays the same premium for Medicare coverage as all other Medicare recipients.

WHEREFORE, Plaintiff prays that this Honorable Court declare the maintenance of separate fee schedules by Defendants Blue Cross and Blue Shield of Michigan and Joseph Califano, Secretary of Health, Education and Welfare, in administering the Medicare Program, void and in violation of Defendant's own promulgated regulations, the Medicare Statute, the Fifth Amendment to the United States Constitution and that this Honorable Court further enjoin Defendants from treating family physicians differently from other physicians for purposes of Medicare reimbursement.

FRIMET, BELLAMY,
GILCHRIST & JEHLE, P.C.

/s/ JAMES R. LITES

James R. Lites
Attorney for Plaintiff

/s/ ALAN G. GILCHRIST

Alan G. Gilchrist
Attorney for Plaintiff

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

No. 6-72082

MICHIGAN ACADEMY OF FAMILY PHYSICIANS,
A NON-PROFIT ASSOCIATION,
CHARLES FARBER, M.D.,
GLENN W. HOUSE, M.D., AND
LESTER WEBB, M.D.,
PLAINTIFFS

v.

BLUE CROSS AND BLUE SHIELD OF MICHIGAN,
SECRETARY OF HEALTH, EDUCATION
AND WELFARE,
DEFENDANTS.

JUDGE JULIAN A. COOK
Filed May 2, 1980

DEFENDANTS' ANSWER TO PLAINTIFFS' SECOND AMENDED COMPLAINT

Defendants, the Secretary of Health, Education and Welfare and Blue Cross and Blue Shield of Michigan, in its capacity as the Secretary's agent under the Medicare Act, by and through their attorney, James K. Robinson, United States Attorney for the Eastern District of Michigan, Michele Coleman Mayes, Assistant United States Attorney, of counsel, in response to plaintiffs' second amended complaint pleads as follows:

FIRST DEFENSE

The second amended complaint fails to state a claim upon which relief can be granted.

SECOND DEFENSE

The Court lacks jurisdiction over the subject matter of this action.

THIRD DEFENSE

Answering specifically the numbered paragraphs of plaintiffs' second amended complaint, defendants plead as follows:

37a. Defendants hereby incorporate by reference their answers to paragraphs one (1) through sixty-three (63) to plaintiffs' [first] amended complaint as though they were fully set forth herein.

37b. In response to paragraph 37b, defendants are without knowledge or information sufficient to form a belief as to the truth of the allegations contained herein.

37c. In response to paragraph 37c, defendants are without knowledge or information sufficient to form a belief as to the truth of the allegations contained therein.

37d. In response to paragraph 37d, defendants are without knowledge or information sufficient to form a belief as to the truth of the allegation contained therein.

37e. Answering paragraph 37e, defendants deny the allegations contained therein.

Defendants hereby specifically deny all allegations of the second amended complaint not hereinbefore otherwise answered.

WHEREFORE, having fully answered, defendants pray that this action be dismissed and that the Court grant such other and further relief as may be appropriate.

Respectfully submitted,
JAMES K. ROBINSON
United States Attorney

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Dated: Detroit, Michigan
May 1, 1980

In the Supreme Court of the United States

No. 85-225

MARGARET M. HECKLER, SECRETARY OF HEALTH AND HUMAN SERVICES, ET AL., PETITIONERS

v.

MICHIGAN ACADEMY OF FAMILY PHYSICIANS, ET AL.

ORDER ALLOWING CERTIORARI. Filed October 7, 1985.

The petition herein for a writ of certiorari to the United States Court of Appeals for the Sixth Circuit is granted.

Supreme Court, U.S.
FILED
DEC 13 1985
SPANIOL, JR.
CLERK

NO. 85-225

In The

Supreme Court of the United States

October Term, 1985

MARGARET M. HECKLER, SECRETARY OF HEALTH AND HUMAN SERVICES, ET AL.,
Petitioners

v.

MICHIGAN ACADEMY OF FAMILY PHYSICIANS, ET AL.,
Respondents

BEST AVAILABLE COPY

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

BRIEF OF THE RESPONDENTS

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I.

QUESTIONS PRESENTED

Did the Court of Appeals correctly conclude that 42 USC Section 1395ff and 42 U.S.C. Section 405(h) do not deprive Respondents of a judicial forum for redress of their substantial statutory and constitutional claims?

If it is determined that 42 U.S.C. Section 1395(ff) and 42 U.S.C. Section 405(h) do authorize an agency of the federal government to violate the Medicare statute or the Fifth Amendment to the United States Constitution with no forum for those affected to take redress, does such lack of forum violate the United States Constitution?

II.

PARTIES TO THE PROCEEDING

Petitioners' description is accurate.

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IN THE SUPREME COURT
OF THE UNITED STATES
October Term, 1985

No. 85-225

MARGARET HECKER, SECRETARY OF
HEALTH AND HUMAN SERVICES, ET AL.,
Petitioners

v.

MICHIGAN ACADEMY OF
FAMILY PHYSICIANS, ET AL.,
Respondents

ON WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

BRIEF OF RESPONDENTS

OPINIONS BELOW

Petitioners' citation to the opinions and judgments below is accurate..

JURISDICTION

The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATUTORY PROVISIONS AND REGULATION INVOLVED

Petitioners' statement as to the statutory provisions and regulations involved are accurate. The statutory provisions and regulations are reproduced in Petitioners' appendix.

STATEMENT

1. Background

This case involves a challenge to a regulation promulgated by the Department of Health and Human Services which permitted differential treatment of certain allopathic (M.D.) family physicians and those patients who chose to be treated by them versus all other allopathic physicians and their patients under the Medicare Program. The differential treatment invalidated by both the trial court and the Court of Appeals is implemented through the creation and maintenance of a separate fee screen which placed family physicians in the same fee screen as podiatrists, chiropractors, and dentists while physicians with different specialties were placed in a separate fee screen consisting only of physicians. The Michigan Academy of Family Physicians, consisting of approximately 1,500 allopathic physicians, is a state chapter of the national organization known as the American Academy of Family Physicians (D.E. 76, Pretrial Order). Family physicians specialize in primary care, sometimes described as first contact care, providing comprehensive health care to the entire family. Family practice is distinct through the treatment of the entire family in a first contact care setting regardless of sex or age. However, there is considerable overlap between specialty areas and other physicians commonly practice primary care including internists, pediatricians, and possibly obstetricians and gynecologists. Family physicians are trained in the context of an office-based practice to treat approximately 90 percent of the medical problems that are presented (testimony of E. Harvey Estes, M.D., D.E. 131 at 15; testimony of Robert Vitu, M.D., D.E. 139 at 32). Family physicians are established as board certified or board eligible by the American Board of Family Practice which was established in 1969. At the time of trial there were 17 approved residency programs in family practice in the State of Michigan including the three medical schools within the State of Michigan, the Uni-

versity of Michigan, Wayne State University, and Michigan State University (Vitu, D.E. 129 at 11).

2. The Medicare Statute

Petitioners' description of the Medicare Program is sufficient and will not be repeated here in detail, except for those provisions that relate to the present case or those provisions not discussed by Petitioners. Under Part B of the Medicare Program the Secretary is authorized to enter into contracts with private insurance companies for its administration. 42 U.S.C. 1395u.

Under Part A, determinations of both "entitlement to benefits" and "amount of benefits" are made by the Secretary. 42 U.S.C. Section 1395ff(a). Under Part B the determination of "entitlement to benefits" is made by the Secretary. Under Part A, an individual disssatisfied with either an eligibility or amount of benefits determination is entitled to a hearing by the Secretary and to judicial review of the Secretary's final decision pursuant to 42 U.S.C. 405(g). In contrast, 42 U.S.C. Section 1395ff(b) provides for a hearing by the Secretary and judicial review of the Secretary's final decision only where an individual is dissatisfied with eligibility determinations under Part B.

The hearing rights of individuals dissatisfied with an "amount of benefits" determination under Part B consists of a hearing before a carrier selected by the agency to administer the Medicare Program, here Blue Cross and Blue Shield of Michigan. Specifically, Section 1395u(b)(3)(C) provides that an individual will be granted an opportunity for a "fair hearing by the carrier" in cases of controversy over $100.00 with regard to services furnished and denied or not acted upon with reasonable promptness.

A fair hearing conducted by the carrier is controlled by regulations promulgated by the Secretary and certain provi-

sions of the "Carrier's Manual."[1] The types of challenges that may be heard by the carrier are carefully delineated by regulation. See 42 C.F.R. 405.801, *et seq*. The regulations provide for a hearing when a party is dissatisfied with a determination denying a request for payment, the amount of payment, or where the request for payment is not acted upon with reasonable promptness. A party is then given a right to a "fair hearing" (42 C.F.R. 405.820) conducted by a hearing officer designated by the carrier (42 C.F.R. 405.823). The jurisdiction of the hearing office is carefully circumscribed by regulations as follows:

> The hearing officer in exercising the authority to conduct a hearing on this Section 1842(b)(3)(c) of the Act is to comply with all the provisions of Title XVIII of the Act and regulations issued thereunder, as well as with policy statements, instructions, and other guides issued by the Health Care Financing Administration in accordance with the Secretary's agreement with the carrier. 42 C.F.R. 405.860.

The restrictions imposed upon the hearing officer's jurisdiction is made even more explicit by the Carrier's Manual, the compilation of guidelines a hearing officer is bound by the above regulation to follow. Section 12016 of the Manual states:

> Authority — the HO occupies a significant position in the administration appeals process affording dissatisfied individuals with hearing rights provided in Section 1842(b)(3)(C) of the Act. Authority of the HO is limited to the extent that he must comply with all provisions of Title XVIII of the Act and regulations issued thereunder, as well as with HCFA rulings, generals instructions, and

[1] The Carrier's Manual was compiled by the Health Care Financing Administration. Its declared purpose is to serve as "practical operation instructions needed by the contractors responsible for the administration of the supplementary and medical insurance program — Part B Medicare." (Forward to Carrier's Manual.)

other guides issued by HCFA with the Medicare Bureau. *The HO does not have the prerogative of overruling the provisions of the law or of interpreting them in a way different than that of the Medicare Bureau when he is in disagreement with their intent; nor may he use hearing decisions as a vehicle for commenting upon the legality, constitutional or otherwise, of any provision of the Act or regulations relevant to the Medicare Program.* (Emphasis added.)

3. Proceedings

Plaintiffs commenced this action on the 8th day of October, 1976 (D.E. 1). The complaint was amended twice (D.E. 68, 78). Plaintiffs consist of the Michigan Academy of Family Physicians, Charles Farber, M.D., Lester Webb, M.D., board eligible family physicians, Glenn House, M.D., a board certified family physician, and Carol Diedrich, a Medicare beneficiary who selected Phillip Lang, M.D., a family physician, as her primary physician. Plaintiffs allege that the different treatment of family physicians, compared to all other types of physicians in the State of Michigan, violated substantive due process requirements of the Fifth Amendment to the United States Constitution and the Medicare statute. Plaintiffs also allege that the failure to provide Plaintiffs a hearing in which Plaintiffs could contest the fee differential violated Plaintiffs procedural due process rights under the Fifth Amendment. Plaintiffs sought no monetary relief but merely a determination that the maintenance of separate fee schedules by Defendants violated the Medicare statute and the Fifth Amendment. Plaintiffs requested that the court enjoin Defendants from treating family physicians differently from all other physicians for purposes of Medicare reimbursement.

Prior to suit, on October 9, 1974, the individual physicians requested a hearing with the carrier to contest the validity of the carrier's actions with regard to separate fee

schedules (D.E. 135, Pl. Ex. 15, 38, and 80)[2]. On March 31, 1975, the carrier indicated that an adjudication as to the reasonableness of the specialty differential could not be involved and the carrier would accept no adjudication which eliminated such a differential (D.E. 135, Pl. Ex. 49). Additionally, Carol Diedrich, without counsel, protested the prevailing fee determination as to services performed by Dr. Lang and was notified by the carrier that she was without recourse and nothing could be done (Diedrich, D.E. 92 at 14).

Prior to trial, the Secretary moved to dismiss Respondents' complaint for lack of jurisdiction as to the statutory claim and as to the constitutional claim on the basis that the claim was insubstantial. In December, 1977, the Secretary's motion was denied by the Honorable James Churchill in the memorandum opinion which noted:

> I am influenced by the improbability that Congress would intentionally authorize an administrative agency to delegate to a private contractor the power to violate the Constitution of the United States in the name of the United States without recourse. (J.A. at 10)

The undisputed facts at trial established that in determining the prevailing fee limitation the carrier established three separate groupings of physicians and non-physicians generally referred to as three "screens." Screen one was generally called the "nonspecialist screen" and consisted of osteopathic and allopathic physicians who were family practitioners, chiropractors, podiatrists, and dentists. Screen two was made up of board certified and non-board certified

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[2] Petitioners did not order a transcript of the entire lower court proceedings. On the first date of trial, September 15, 1980, all but a few of Plaintiffs' exhibits were admitted without objection. The transcript of the admission of these exhibits was not produced. However, all exhibits cited herein were transmitted to the Sixth Circuit and are reflected in the Joint Appendix as Docket Entry 135. Counsel have agreed that the exhibits referenced herein were admitted at the lower court and have agreed to refer to the exhibits by number and docket entry.

osteopathic and allopathic internists for in-patient hospital services only. Screen three, commonly referred to as the "specialist screen" was made up of all osteopathic and allopathic board certified family physicians, all physicians other than family physicians, whether board certified or not, both osteopathic and allopathic (D.E. 76, pretrial order). In addition, physicians who practice as a group of at least three were placed within the third or the specialist screen regardless of specialty board status (D.E. 133 at 20-21).

For purposes of determining the prevailing fee limitation, all charges within each screen are grouped together so that the prevailing fee is established at that dollar amount that will pay 75 percent of all charges. 42 U.S.C. 1395u. Physicians billing Medicare use a document called a "Physician's Manual" which lists approximately 3,000 separate procedure code numbers with a description of the service performed for each individual number (D.E. 135, Pl. Ex. 83). Prevailing fee limitations are established for each of the approximately 3,000 procedure code numbers. The effect of this multiple fee calculation was a different prevailing ceiling depending on the individual patient's choice of treating physician. For example, in the case of office visits (which represent 40 percent of all payments under Part B of the Medicare program) the prevailing fee limitation for 1980 in the Lansing, Michigan area is represented in the following chart:

PREVAILING FEE LIMITATIONS

Service	Screen 1	Screen 2 (Hospital Visits Only)	Screen 3
Initial Comprehensive Office Visit	$25.00	N/A	$50.00
Follow-up Office Visit	$10.70	N/A	$12.30
Inpatient Hospital Visit	$35.70	$50.00	$50.00

When patients such as Diedrich choose a family physician who refuses to accept such differentials, the difference in reimbursement must be made up by the patient (D.E. 92 at 10, 14).

Petitioners have referred to screen 1 as a "GP screen" and screen 2 and 3 as "specialist screens." In fact, the grouping may be more appropriately labelled as non-M.D. dominent (I) and M.D. dominent (II, III). The three screens consist of the following types of health care providers:

(A) Screen 1 — 1,276 allopathic family physicians, 937 osteopathic physicians, 437 podiatrists, and 632 chiropractors,

(B) Screen 2 — 1,616 allopathic physicians, 172 osteopathic physicians, and

(C) Screen 3 — 7,837 allopathic physicians, 888 osteopathic physicians (D.E. 135, Pl. Ex. 31, 44).

The podiatrists and chiropractors who nearly equal the number of the allopathic family physicians placed within screen 1, are carefully limited in terms of the treatment they may render. See M.C.L.A. 333.18001(1)(d); M.C.L.A. 333.16401(1)(b), *DeHart* v *Board of Podiatry*, 97 Mich. App. 307 (1980); *Demido* v *Attorney General*, 100 Mich. App. 254 (1980). Both licenses require two years of education in an accredited school and, depending on the date obtained, a high school degree (or equivalent) or two years of undergraduate experience.

In contrast, the allopathic physicians placed within this grouping consist of recent family physician residency graduates who have not yet taken the certifying examination or in the alternative, allopathic physicians who graduated from medical school prior to the establishment of the American Board of Family Practice of 1969, but have the benefit of years of experience in their field.

At trial numerous individuals testified including physicians; Robert Vitu, M.D. (a board certified family physician); E. Harvey Estes, M.D. (a board certified internist and cardiologist, and member of the Institute of Medicine, which is the medical branch of the National Academy of Sciences); and Phillip Lang, M.D., a non-board certified family physician. Also testifying was Paul Feldstein, Ph.D., (Professor of Economics at the University of Michigan, Department of Public Health) and various employees of the carrier and HHS including William Boyles (carrier employee who had the responsibility for establishing the Medicare reimbursement program in the State of Michigan at the inception) and Louis Hayes, M.D. (Medical Director for the carrier).

Dr. Lang is a family physician who had practiced in Lansing, Michigan for 23 years as of the date of trial. He graduated from Wayne State University Medical School in 1948 at a time when formal family practice residency programs were not available to graduates. He is a professor at Michigan State University teaching students in family practice (D.E. 124 at 47). Respondent Carol Diedrich is a Medicare recipient who had been treated by Dr. Lang for over 23 years at the time of trial. Dr. Lang treats her parents, her younger brother, older sister, and has delivered her three children (D.E. 124 at 44-47). Diedrich is a Medicare recipient by virtue of disability. The record reflects repeated reductions in claims submitted by Diedrich as a result of the multiple screen reimbursement mechanism utilized in Michigan (D.E. 135, Pl. Ex. 67, D.E. 92 at 10). She has attempted to determine the reason for reduction in reimbursement and has been told by the carrier that it was reduced based upon prevailing fees and nothing could be done about it (Diedrich D.E. 92 at 14). Diedrich realized that her out-of-pocket expenses would be less if she was treated by a specialist, but she refuses to change physicians because Dr. Lang treats all her problems and because he treats her entire family (D.E. 92 at 14).

Petitioners have not seen fit to appeal the lower court decisions on the merits (see Petition for Writ of Certiorari, October Term, 1984, fn. 5, Petition for Writ of Certiorari, October Term, 1985, fn. 11). Nonetheless, Petitioners brief goes into substantial detail in an attempt to demonstrate a rationale for the regulation invalidated by both the district court and the U.S. Court of Appeals (Pet. brief at 7, 43, 44). Petitioners' brief reduces to a footnote a key concession at trial being that the Government had no rationale in support of its treatment of board eligible family physicians (Pet. brief at fn. 2). In fact, while stipulating that it had no rationale, the Government declined at trial to afford Respondents any relief (D.E. 132 at 63).

Petitioners assert that the regulation in question reflects the Congressional intent to reflect the marketplace in implementing reasonable charge calculations under the Medicare Program. While there is support for the proposition that Congress intended to reflect the marketplace in determining reasonable charges under the Medicare Program and to use carriers such as Blue Cross and Blue Shield plans to achieve this purpose, there is absolutely no support in the record that the regulation in question, 42 C.F.R. 405.504(b), furthered this purpose. Testimony established that prior to the implementation of the Medicare Program the carrier made no distinction between physicians according to specialty for purposes of determining the amount of payment under their private business (Boyles D.E. 131 at 34). The Medicare statute was modeled after a program known as the "Variable Fee Program" established by the National Blue Shield Plan for determining physicians' reasonable charges. The National Blue Shield Plan provided no distinctions in calculating the prevailing fee based upon a physicians specialty (Boyles D.E. 131 at 35-36, D.E. 135, Pl. Ex. 24). Carrier employees further testified that they prepared a proposal for the contract as the carrier in Michigan modeling this proposal after the Variable Fee Program. The first proposal did not draw any distinction between family physicians and

other type of allopathic physicians (Boyles, D.E. 131 at 34). These employees were notified that the government "preferred" specialty screens (Boyles, D.E. 131 at 37). In short, the Secretary added a new requirement in determining reasonable charges reflected neither in the marketplace nor in the program the Medicare statute patterned itself after.

The attempt of Petitioners to characterize the physicians within the specialty screen as performing a higher level of service and therefore not similar, is also repudiated by unrebutted testimony at trial. It is a well recognized phenomena that specialists in areas other than primary care are performing primary care procedures. Studies have indicated that approximately 50 percent of a specialty physician's medical services are in areas outside of the physician's specialty. This is particularly true of general surgeons as there is an excess number of general surgeons in Michigan and a shortage of family physicians (Estes, D.E. 131 at 9; Hayes, D.E. 87 at 104, 130). Statistics would indicate that 73 percent of the surgeons in Michigan spend ten to 25 percent of their time in primary care (Hayes, D.E. 87 at 102). There was also testimony to demonstrate the causal effect between the excess number of specialists and higher medical costs (Hayes, D.E. 87 at 130).

In the face of this unrebutted testimony, Petitioners suggest that the question of similarity of service is a matter within the Secretary's discretion and such determinations were delegated by Congress to the Secretary and carrier (Pet. brief at 6, 26). Such an assertion ignores the clear and unequivocal language of 42 U.S.C. 1395u(b)(3) which states that in determining reasonable charges,

> No charge may be determined to be reasonable in the case of bills submitted or request for payments made under this Part . . . if it exceeds the higher of (i) the prevailing charge recognized by the carrier and found acceptable by the Secretary for *similar services* in the same locality . . . or (ii) the prevailing charge level that,

> on the basis of statistical data and methodology acceptable to the Secretary, would cover 75 percent of the customary charges made for *similar services* in the same locality during the last preceding calendar year . . . (Emphasis added).

While intimating that the Secretary considered the issue of similarity of services in promulgating the regulation Petitioners have failed to cite any portion of the trial record for this suggestion. In fact, all witnesses whether called by Petitioners or Respondents indicated otherwise. All the government witnesses, whether from the central office of HHS, the regional office of HHS, or the carrier agreed that the statutory phrase "similar service" means submission of the same procedure code number under the Physician's Manual (Remington, D.E. 133 at 8; Riesel, D.E. 132 at 69; Barnett, D.E. 124 at 6-7). Additionally, the medical testimony was unanimous that the medical practices most similar to each other in primary care were internists and family physicians and that when the same medical description is utilized by physicians (such as comprehensive examinations or limited examinations) the services are similar. The professionals testifying to this effect included the carrier's own Medical Director (Hayes, D.E. 87 at 140), the Plaintiff family physicians (Vitu, D.E. 129 at 35-37), and E. Harvey Estes, M.D., an internist (D.E. 131, at 5-8). In fact, the relief granted by the Court after modified by the U.S. Court of Appeals for the Sixth Circuit did nothing more than require the Secretary to consider the statutory mandate for similar services regardless of who performs that service. In response to the U.S. Court of Appeals' order, the government eliminated all multiple screens within the State of Michigan and established a single prevailing fee calculation for each individual medical service regardless of who performs that service. Thus, once applying the statutory language, Petitioners abandoned the separate screen concept as inconsistent with the statutory language. Stripped of its rhetoric, the government's brief is nothing more than a continuation of the gov-

ernment's repeated attempt to ignore this clear legislative mandate.

On December 30, 1980, the Honorable Horace Gilmore issued his opinion in *Michigan Academy of Family Physicians* v *BCBSM*, 502 F. Supp. 701 (E.D. Mi. 1980). In holding for Respondents the Court noted:

> There is no basis to justify the segregation of allopathic family physicians from all other types of physicians. Such segregation is not rationally related to any legitimate purpose of the Medicare statute. To lump M.D.s who are family physicians, but who have chosen not to become board certified family physicians for whatever motive, with chiropractors, dentists, and podiatrists for the purpose of determining Medicare reimbursement defies all reason. (Pet. App. 31a)

The district court found the regulation authorizing such a classification scheme to be plainly inconsistent with the Medicare statute which "mandates the customary charges of physicians for similar services be the test for reimbursement" (Pet. App. 30a).

The district court furthermore found that this classification scheme violated yet another provision of the Medicare Act, 42 U.S.C. Section 1395a because it intended to influence a beneficiary's choice of physician and reduce that beneficiary's reimbursement solely by virtue of the choice of the type of physician to perform a particular medical service. Since the district court found the Secretary's and carrier's actions to be a clear violation of the Medicare Act, it did not consider the constitutional arguments advanced by Respondents. (Pet. App. at 32a).

In an opinion dated February 23, 1984, the Court of Appeals affirmed the district court's rulings on jurisdiction and on the merits except for remanding the case to the Secretary for reconsideration of the reimbursement plan

with the proper focus of "similar service" (Pet. App. 1a-15a). As to jurisdiction, the Court of Appeals recognized that this Court's decision in *United States* v *Erika*, 456 U.S. 201 (1982), held that Congress clearly and convincingly intended no judicial review of amount of benefits cases. After a review of the applicable statutes and case law, the Court, however, concluded that jurisdiction did exist under the particular circumstances of this case since there would be no other forum for Respondents to press their statutory and constitutional claims (Pet. App. 8a, 9a).

As to the merits of Respondents' case, the Court of Appeals found that the "touchstone" of 42 U.S.C. Section 1395u(b)(3) is "similar service" and there was an obvious inconsistency between the statute and the disputed regulation. The Court of Appeals found the regulation "irrational" and "invalid" (Pet. App. 13a). Because the regulation was statutorily unsound, the Court did not address the constitutional issues raised in the case (Pet. App. 13a).

Following a petition for writ of certiorari by the Secretary, this Court granted the petition, vacated the judgment in Court of Appeals, and remanded the case to the Court of Appeals for further consideration in light of *Heckler* v *Ringer*, __ U.S. __; 104 S. Ct. 2013 (1984), *Heckler* v *Michigan Academy of Family Physicians)*, No. 84-102 (October 1, 1984). On remand, the Court of Appeals first ordered the case dismissed for lack of jurisdiction (Pet. App. 16a), but on Respondent's petition for rehearing the Court reconsidered and found jurisdiction under 28 U.S.C. 1331 (Pet. App. 17a-22a). Contrary to the assertions of Petitioners that the U.S. Court of Appeals ignored this Court's decision in *Ringer, supra*, the opinion of March 19, 1985 juxtaposed the positions of both the Petitioners and Respondents as to the effect of *Ringer* on the Court's previous decision (Pet. App. 20a, 21a). The Court noted that Respondents argued that Petitioners' interpretation of *Ringer* would expand this holding to any challenge under Part B of the Medicare Pro-

gram and effectively preclude any review, a result that would raise serious constitutional questions (Pet. App. 20a). The Court noted that the position of the Secretary was that Respondents could obtain no judicial review of its cause of action and that fn. 4 of *Ringer* was controlling and compelled dismissal of this action (Pet. App. 21a). While stating that the case was one of first impression and presents a close question, the Court found jurisdiction because of the absence of any alternative forum (Pet. App. 22a).

The petition and brief of Petitioners in this matter postures the case such as this Court is to decide whether Congress has effectively precluded any administrative or judicial review of Respondents' statutory and constitutional claims.

SUMMARY OF ARGUMENT

This case presents the issue of whether the Department of Health and Human Services can develop a system of hearings and review that effectively preclude any possibility for the redress of substantial statutory and constitutional claims. There is no question that Congress intended to preclude from judicial review those claims justiciable through the Part B hearing process established pursuant to 42 U.S.C. Section 1395u(b)(3). *Erika, supra*. There is likewise no question that where the Social Security statute provides an avenue for judicial review, such avenue is exclusive and must be followed by any claimants. See *Weinberger* v *Salfi*, 422 U.S. 749 (1975), *Ringer, supra*. Under Petitioners' interpretation of the legislative history and the above cases, however, there can be substantial statutory and constitutional issues for which no review in any forum is available. Petitioners reach this conclusion by expanding the *Erika* decision to apply not just to a claim for benefits, but to any challenge under the Medicare statute other than eligibility. This expansion is evident from the outset of Petitioners' argument wherein they characterize the preclusion of judicial review under 42 U.S.C. 1395ff and 405h as encompassing any challenge "affecting the amount of benefits" payable for medical services under Part B of the Medicare Program (Pet. brief, Question Presented).

Petitioners seek further support for their position from language in the *Ringer, supra*, and *Salfi, supra*, decisions which clearly did no more than require that claimants utilize the administrative and judicial review provisions of the Social Security Act, specifically 42 U.S.C. 405 when available to address the claim at issue.

In this case, Respondents requested an administrative review, but were informed that no such review was available to address the very claims which Respondents wished to pursue. The regulatory and administrative authority pertinent in this matter, in fact, stripped the administrative pro-

cess of the ability to resolve the claims pressed by Respondents. The decisions of this Court have never concluded that 405h or 1395ff preclude jurisdiction over substantial statutory and constitutional claims for which no other review is accorded. Rather, this Court has, in fact, addressed substantial constitutional claims arising out of the Medicare Program. See *Schweiker* v *McClure*, 456 U.S. 188 (1982). This Court's decisions in *Salfi*, *Erika*, and *Ringer* stand for the proposition that claimants must first pursue any administrative remedy before asserting federal court jurisdiction and that federal court jurisdiction is precluded for "amount of benefit" cases. The present case is not properly characterized as an amount of benefit case since Respondents, as in *McClure*, made a broad statutory and constitutional claim against a federal regulation. As in *McClure* there was no administrative forum to address these issues. The claims made did not address the specific amount to be paid, but rather addressed a classification scheme inconsistent with the mandate of the Medicare statute. These claims are certainly not insubstantial as the district court found the statutory violation and that court's decision was affirmed by the Court of Appeals. The Petitioners challenge the lower court only on the issue of subject matter jurisdiction.

The construction of Section 405h and 1395ff advanced by Petitioners would allow Petitioners to violate the law with impunity. Indeed, in the district court Petitioners admitted they had no rationale for at least a portion of its classification, refused the district court's suggestion that a remedy be fashioned, yet now insist that no forum exists for the redress of the very violation they concede. It is respectfully suggested that this Court must interpret 405 U.S.C. 405(h) and 1395ff in such a fashion as to avoid such a serious constitutional issue and in a fashion which also gives meaning and effect to the various provisions of the Medicare Act.

ARGUMENT

I. NEITHER THE MEDICARE STATUTE NOR THE LEGISLATIVE HISTORY SUPPORT THE PROPOSITION THAT, WHILE CONGRESS PROVIDED AN ADMINISTRATIVE FORUM FOR MINOR DISPUTES SUCH AS THE AMOUNT OF PAYMENT ON AN INDIVIDUAL CLAIM, IT INTENDED NO FORUM WHATSOEVER FOR STATUTORY AND CONSTITUTIONAL CLAIMS.

Through the last several years this Court has had three occasions to consider the administrative review mechanisms of the Social Security Act and the related issue of federal court jurisdiction. *Salfi, supra, Erika, supra,* and *Ringer, supra.* In addition, this Court has previously addressed, without any significant discussion of jurisdiction, a constitutional challenge to the administrative review mechanisms under Part B of the Medicare Program. *Schweiker* v *McClure,* 456 U.S. 188 (1982). Any analysis of the impact of these decisions must be viewed in the context of the administrative review mechanisms under Part A and Part B of the Medicare Program. Petitioners have gone into great depth describing the distinctions in the review mechanism under Part A as compared to Part B (Pet. brief at 2), but would appear to abandon such distinctions in their analysis of the above cases. Contrary to Petitioners' suggestion, a review of these decisions indicate that this Court has never interpreted the provisions of the Social Security Act as foreclosing all forums to redress substantial statutory or constitutional issues.

The critical statutory provisions in any analysis of Part B of the Medicare statute and the above case law are Section 1395ff, Section 405, and Section 1395u(b)(3). There are two fundamental flaws to Petitioners' analysis of these statutory provisions as they apply to Respondents' claim. First, the Petitioners attempt to apply the scope of the Section 405 review provisions and select language within *Salfi,* and *Ringer,* to this case. In fact, the review mechanism under

Section 405 has never been available to Respondents and the language of Section 405h simply cannot be interpreted to apply to Respondents' claim. Secondly, Petitioners have failed to acknowledge the limited scope of review available to the fair hearing process established by Section 1395u(b)(3). Petitioners acknowledge briefly the limited jurisdiction of the carrier hearing mechanism (Pet. brief at 15), but then proceed to expand the jurisdictional bar under *Erika* to matters not justiciable in the carrier hearing process. While it is clear that there is no judicial review afforded for fair hearing decisions under Section 1395u(b)(3) Petitioners wish to expand this jurisdictional bar to any claim under Part B of the Medicare Program "affecting" or "concerning" the amount of benefits under Part B, (Pet. brief, Question Presented, at 17, 18). Neither a consistent reading of the statute nor the legislative history supports such an expansive view of the Congressional intent to bar judicial review. A consistent reading of the Medicare statute and the legislative history indicates that Congress intended only to bar those claims justiciable under Section 1395u(b)(3). In essense, Section 1395ff and Section 1395u(b)(3) must be read consistently. The legislative history evidencing an intent to bar judicial review of amount of benefit cases must be read consistent with the statutory provision providing carrier hearings for amount of benefit cases under Part B. The expansion of the legislative history of 1395ff to any challenge affecting the amount of benefits provides a vacuum wherein no forum whatsoever is available for substantial statutory and constitutional claims. Respondents submit that if Congress intended this result, somewhere within the body of the Medicare statute or the legislative history such intent would be disclosed. This Court's previous decisions on Social Security cases, the legislative history, and the Medicare statute itself simply do not support Petitioners' position.

A. 42 U.S.C. 405(h) DOES NOT BAR JURISDICTION UNDER 28 U.S.C. 1331 FOR PART B MEDICARE DISPUTES.

Section 1395ii provides that Subsection 405(h) "shall apply with respect to this subchapter to the same extent as . . . applicable with respect to subchapter II of this chapter."

Section 405(h) of the Social Security Act provides:

> The findings and decisions of the Secretary after a hearing shall be binding upon all individuals where parties to such hearing. No findings of fact or decisions of the Secretary shall be reviewed by any person, tribunal, or governmental agency expect as herein provided. No action against the United States, the Secretary, or any officer or employee thereof shall be brought under Section 1331 or 1346 of Title 28 to recover on any claim arising under this subchapter.

Section 405(g) provides that any individual after a final decision of the Secretary made after a hearing may obtain review of such decision by a civil action within 60 days brought in the District Court of the United States.

It is Petitioners' position that since Section 405(h) was incorporated into the Medicare Act by Section 1395ii and Section 405(g) was not, Congress clearly intended to foreclose judicial review of all matters under Part B with the exception of eligibility for which judicial review is specifically provided under 1395ff. Despite Petitioners' reliance upon *Erika*, this Court specifically declined in that case to decide the impact of 405(h) on Medicare Part B. See *Erika*, *supra*, fn. 6.

Whether Section 405(h) is applied in a strict literal fashion or, as is dictated by Section 1395ii, "to the same extent to which it is applicable to Title II of the Social Security

Act," Plaintiffs reliance upon the language of 405(h) is misplaced.

405(h) bars judicial review of "the findings and decision of the Secretary after a hearing." In this case no hearing of any sort is available to Respondents, and certainly no hearing is available before the Secretary. Likewise, there were no findings of fact or decision by the Secretary to be reviewed and there is no mechanism within Part B for any findings of fact or decision of the Secretary pertaining to Respondents' claim. Additionally, this case cannot be construed as an action against the United States, the Secretary, or any officer or employee to recover on any claim.

Petitioners ignore the clear language of 405(h) which limits its application to findings and decisions of the Secretary and actions against the United States, Secretary, or officer or employee. Clearly, Blue Cross and Blue Shield enjoys no such status.[3] See *National Association of Patients on Hemodialysis* v *Heckler*, 588 F. Supp. 1108, 1117 (D.C. D.C. 1984).

Just as the statutory language does not support Petitioners' position, the previous decisions of this Court relating to 405(h) simply do not reach the conclusion urged by Petitioners in this case.

In *Weinberger* v *Salfi*, *supra*, this Court faced a constitutional challenge to provisions of the Social Security Act and carefully reviewed each of the three sections contained within Section 405 and concluded that 405(h) constitutes more than a requirement for exhaustion of administrative remedies. The Court further rejected any narrow reading of

[3] In fact, where the Secretary makes findings and decisions on eligibility and amount of benefit matters, it is pursuant to 405(b) with judicial review provided under 405(g). (See 1395ff, Pet. brief at 3.) An expansion of the literal wording of 405(h) to findings and decisions of the carrier distorts the clear import of 405(h) that the prerequisites of the balance of Section 405 must be complied with when available.

the language "any claim arising under . . . the Social Security Act" since the statute provided "both the standing and substantive basis for the presentation of . . . constitutional contentions." Significant in the *Salfi* decision is the distinction of the prior case of *Johnson* v *Robison*, 415 U.S. 361 (1974), the Court noting that acceptance of the government's interpretation of the statute in that case would have meant that no judicial consideration of a constitutional challenge could have taken place. The Court stated:

> Not only would such a restriction have been extraordinary, but such "clear and convincing" evidence would be required before we could have ascribed such intent to Congress . . . but it would have raised a serious constitutional question of the validity of the statute so construed.
> 422 U.S. at 763 (citations omitted).

It is clear from reviewing the decision in *Salfi* that this Court was concerned that Section 405(h) not be interpreted to preclude constitutional challenges. The principle was neither ignored nor forgotten in the subsequent decisions of this Court.

Heckler v *Ringer, supra*, the other decision focusing on Section 405(h), was limited in the main to a discussion of judicial review of a Part A claim. *Heckler* v *Ringer, supra* fn. 4. Respondents' challenged an instruction by the Secretary which denied Medicare reimbursement for a particular surgical procedure. This Court distinguished between the Respondents since three of the Respondents had had the surgery performed prior to the Secretary's limiting instructions whereas a fourth Respondent (Ringer) had yet to undergo the surgery claiming that he could not afford to do so if it was not a covered benefit. Before the administrative review available under Part A had been completed, a challenge was made to the Secretary's limiting instruction through filing suit in federal district court. The precise issue faced by this Court was whether the Respondents could

pursue their claim in federal district court prior to having their claims first channeled into the administrative process available under Part A and, in the case of Respondent Ringer, before the surgery was actually performed.

This Court held that Section 405(h) barred federal court jurisdiction over the Respondents' claims since Respondents had failed to exhaust their administrative remedies provided under Section 405(g) in the confines of their Part A claims. As to Respondent Ringer, this Court declined the invitation not to enforce the provisions of Section 405(h) to a Medicare claimant who had yet to undertake the surgery since to do otherwise would have opened the door and allowed a bypass of the administrative remedy provided by the Act. This Court noted:

> If we allow plaintiffs in Ringer's position to challenge in federal court the Secretary's determination . . . that BCBR surgery is not a covered service, we would be inviting them to bypass the exhaustion requirements of the Medicare Act by simply bringing declaratory judgment actions in federal court before they undergo the medical procedure in question.
> 104 S. Ct. at 2025.

B. 42 U.S.C. 1395ff AND THE LEGISLATIVE HISTORY OF MEDICARE PART B DO NOT BAR JUDICIAL REVIEW OF ALL STATUTORY AND CONSTITUTIONAL CLAIMS RELATED TO MEDICARE PART B.

The previous decision of this Court that dealt with Part B and Section 1395ff is *Erika, supra*. The judicial action in that case was commenced following an administrative review by the carrier pursuant to 42 U.S.C. 1395u(b)(3)(C). The substantive challenge boiled down to the carrier's determination to base "reasonable charge" upon a price list utilized by Respondent-Provider. There was no constitutional

claim pressed before this Court. See *United States* v *Erika*, *supra*, at fn. 5.

Because 1395ff failed to provide for a hearing by the Secretary (or judicial review thereafter) for "amount of benefit" cases under Part B, and because the legislative history revealed an intent to distinguish between "amount of benefit" cases under Part B and other types of challenges for purposes of judicial review, this Court determined that the administrative hearing afforded in *Erika* was appropriate and no further judicial review was permissible.

Contemporaneously with issuing the *Erika* opinion, this Court also handed down its opinion in *Schweiker* v *McClure*, *supra*. The *McClure* case once again dealt with Part B of the Medicare Program, but was distinct from *Erika* in that the challenge in that case was directed at the hearing procedure mandated by 42 U.S.C. 1395u(b)(3)(C) implemented through regulation. Like the present case, the claim presented by Respondents in *McClure* could not be addressed at the carrier hearing. Relevant to this discussion, the Court did not consider the jurisdictional issue, but went on to substantially address the constitutional claims and ruled that the carrier hearing, as mandated by statute and implemented through regulations, was constitutional. *McClure* was notably distinct from *Erika* since the issues brought before the federal district court were not amount of benefit issues which could be addressed at the administrative hearing, but were rather broad constitutional challenges to overall administrative review to the overall administrative review process adopted by the Secretary and acted upon by the carrier.

From these precedents, Petitioners weave their argument for relief from this Court. From the *Salfi* opinion they take the principle that Section 405(h) applies to any action "arising under" the Medicare Act. From the *Erika* opinion they take the principle that all "amount of benefit" cases are without recourse to judicial review. From the *Ringer* opinion

they take the principle that the administrative channels and judicial review established by Section 405(g) and Section 405(h) cannot be circumvented by premature district court action by clothing benefit cases in procedural dress. Petitioners then characterize the present cases as an "amount of benefits" case which "arises under" the Medicare Act and is hence without federal court jurisdiction. Despite Petitioners' best efforts, the precedent of these cases cannot collectively establish the principle that judicial review is foreclosed in a Part B Medicare case in which a statutory and constitutional challenge is made and for which there is no administrative process to address these challenges. Indeed, the decisions of this Court stand for quite the opposite when read in proper context with appropriate review of both the statutory provisions and the legislative history.

Section 1395u(b)(3) provides as follows:

> Each such contract shall provide that the carrier —
>
> (C) will establish and maintain procedures pursuant to which an individual enrolled under this Part will be granted an opportunity for a fair hearing by the carrier, in any case where the amount in controversy is $100 or more, when requests for payments under this Part with respect to services furnished him are denied or are not acted upon with reasonable promptness or when the amount of payment is in controversy . . .

Section 1395ff provided for judicial review on eligibility issues under Part B of the Medicare Program, but was silent as to other issues. From this silence Petitioners in essence seek to preclude judicial review of all Part B issues including those issues which cannot be adjudicated in the carrier hearing process. Such expansive reading of the Congressional intent is not supported within the legislative history relied upon by this Court in *Erika*. The Committee reports accompanying the original enactment of the Medicare stat-

ute clearly describe the preclusion of judicial review under Part B as pertaining to those matters for which a carrier hearing is available under 1395u(b)(3):

> *(Under the supplementary plan [Part B] carriers, not the Secretary would review beneficiary complaints regarding the amount of benefits, and the bill does not provide for judicial review of a determination concerning the amount of benefits under Part B where claims will probably be for a substantially smaller amount than under Part A)* . . . (S. Rep. No. 404, 89th Cong., First Sess., 54-55 (1965), U.S. Code Cong. and Admin. News 1965, pp. 1943, 1995 (Emphasis added).

Likewise, the Conference Committee on the 1972 amendments of Section 1395ff stated as follows:

> Clarification of Medicare Appeal Procedures.
>
> Amendment No. 561; the Senate amendment added a new section to the House Bill which would make clear that there is no authorization for an appeal to the Secretary or for judicial review on matters *solely* involving amount of benefits under Part B, . . .
> H.R. Rep. No. 92-1605, 92nd Cong., 2nd Sess. 61 (1972), U.S. Cong. and Admin. News 1972, pp. 4989, 5394. (Emphasis added.)

As pointed out, *supra*, the jurisdiction of the hearing officer is carefully circumscribed by regulation and the carrier and the hearing officer is without jurisdiction of considering the legality of the Medicare statute, regulations or guidelines issued by HHS.

Respondents claim simply is not a claim for benefits justiciable in a Part B hearing for which judicial review is barred under the legislative history. The reasonable charge calculation under the Medicare Programs requires an accumulation of similar services to establish a ceiling at that figure which will pay 75 percent of all claims submitted. See

42 U.S.C. Section 1395u(b)(3). Respondents sought the elimination of specialty screens, not the transfer of individual claims from the "generalist screen" to the "specialist screen." The latter remedy would be totally contrary to the crux of Respondents' claim that the maintenance of different screens among physicians for the same service violated the Medicare statute and the United States Constitution. Respondents claims were delineated to address the groupings or classification scheme itself and the illegal and unconstitutional aspects of the disputed regulation. Since Respondents' complaint related to these groupings, a payment dispute on an individual claim could not afford the relief requested. Rather, the overall grouping mechanism had to be reviewed in the context of Petitioners' statutory authority for its actions. Nothing highlights this distinction more than the effect on board certified family physicians such as Respondent Glenn House, M.D. Under the relief sought by Respondents, success on the merits would reduce the amount of payment to Dr. House, who had been placed in the specialist screen.

Petitioners complain of the broad impact of the lower court's decision on the merits (Pet. brief at 26), yet cite the legislative history barring judicial review of individual claims as applicable. The relief Petitioners complain of simply involves a remand of the Secretary with instructions to consider similar service as a criteria for the determination of reasonable charges (Pet. App. 14a, 15a). A Part B adjudication on an individual claim or even on every entry submitted by the Respondents could not address the statutory violation. Rather, every claim submitted under Part B of the Medicare Program in the State of Michigan had to be regrouped in order to comply with the statute. This is exactly what the Secretary did upon remand. Far more thorough than Petitioners' characterization of Respondents' case as a challenge "affecting the amount of benefits" was the analysis of the Court of Appeals on this issue:

> In this case BCBSM contends this suit involves simply a dispute over the amount of reimbursement due. In a word, BCBSM contends, Michigan Academy is simply seeking to have family physicians and their patients moved to the more lucrative specialty screen, boiling down to an argument for an increase in amounts reimbursed. *Erika*, it concludes, should bar this suit outright. This argument, however, is without merit.
>
> While the eventual result of this suit may cause an increase in amounts of reimbursement, this does not necessarily follow. In some cases the result may be an increased amount of reimbursement and in other cases a reduction in reimbursement could occur. Michigan Academy, at bottom line, is challenging the overall mechanism for determining the amounts of reimbursements, not the actual value of any particular reimbursement. (Pet. App. at p. 8a).

Although it is clear under *Erika* that Congress did intend to foreclose judicial review of Part B claims which challenge payment for a given service, Petitioners' position paints with too broad a brush and would foreclose those claims not within the authority of the hearing officer to decide. Respondents submit that simple logic dictates that the words "amount of benefits" be given a consistent reading. The legislative history which clearly intends to preclude judicial review of Part B carrier hearing decisions must be read consistent with 1395u(b)(3)(C) and the regulations promulgated thereunder which specifically preclude a carrier hearing for the type of issues raised by Respondents. The case at bar involves a statutory and constitutional challenge to a regulation promulgated by HHS, and is not an amount of benefit case which can be adjudicated through the Part B carrier hearing process. Since the determination of these challenges are beyond the carrier's authority, the legislative history concerning judicial review of carrier determinations have little application.

The Petitioners' attempt to chastise the U.S. Court of Appeals for its most recent opinion amply demonstrates the tendency of the Petitioners to merge the requirements of Section 405(h) and the amount of benefit cases precluded by the legislative history describing Section 1395ff.

Petitioners criticize the Sixth Circuit on the basis that the Court characterized *Ringer* as not relying upon Section 1395ff. In fact, *Ringer* was a Part A case rendering the legislative history of 1395ff inapplicable. The hearing and judicial review provisions of 405(b) and (g) were applicable to the claim made in *Ringer.*

Surely, had Congress intended to preclude all challenges under Part B of the Medicare Program for all cases other than eligibility, including statutory and constitutional challenges, Congress would have said so, if not within the statute, at least within the legislative history. See *Abbott Laboratories* v *Gardner,* 387 U.S. 136 (1967).

Finally, Petitioners suggest that the opinion of the U.S. Court of Appeals in this case would foster widespread litigation over minor disputes which in part precipitated this Court's decision in *Erika.* Such an assertion simply ignores what Respondents have already conceded, there is no judicial review for those issues justiciable in a Part B carrier hearing. Such issues include whether or not the services rendered were medically necessary (contrast Part A, *Breeden* v *Weinberger,* 377 F. Supp. 734, 738 (N.D. LA. 1974); *Westgard* v *Weinberger,* 391 F. Supp. 1011, 1018 (D.C. N.D. 1975)), and whether or not the level of service billed under the Physician's Manual is documented within the medical records. Such issues are best left to the carrier which has both the expertise and experience in dealing with such issues in its private insurance program and is consistent with the legislative history barring judicial review on an individual claim.

In fact, the Sixth Circuit has recognized the holding in *Erika* in denying jurisdiction on a claim for payment for a particular service under Part B of the Medicare Program, both prior to and subsequent to the rendering of its decisions in this case. In *Hertzog* v *Secretary*, 682 F. 2d 121 (6th Cir. 1982) the Court of Appeals for the Sixth Circuit faced a case in which the claimants disputed the denial of reimbursement for chelation therapy. Claimants sought and were provided an administrative review of this adverse decision. They subsequently filed suit in the federal court, but made no constitutional challenge to the determination until an adverse district court opinion led to the Court of Appeals' review. The Court of Appeals, relying extensively on this Court's opinion in *Erika* ruled that federal court jurisdiction did not exist to hear the claimant's amount of benefit case.

Most recently in *Good Samaritan Medical Center* v *Secretary of Health and Human Services*, No. 84-3923 (November 7, 1985) the Sixth Circuit recognized under *Ringer* that Section 405(h) bars Part A Medicare cases where recourse is not attempted through the administrative procedures set forth within Section 405, specifically distinguishing its prior decision in this case on the basis that Respondents here "could only reach the federal courts under the jurisdiction grant of Section 1331" (sl. op. at 11).

Petitioners argue that the Sixth Circuit decision would permit judicial review under Part B whenever a claimant characterizes a challenge to an amount of benefits payable under Part B as a challenge to a regulation of the Secretary or a general policy of the carrier that has a bearing on the disposition of individual claims (Pet. brief at 17). Such an assertion ignores the limited impact of the lower court's opinion in this case as evidenced by the Sixth Circuit's own prior and subsequent decisions. This Court in the past has drawn distinctions between factual application of statutory standards and a misconstruction of the governing legislation. See *Lindahl* v *Office of Personnel Management*, ____ U.S.

____; 105 S. Ct. 1620 (1985). One would expect the lower courts to adhere to such a distinction. Clearly, the Sixth Circuit has done so.

C. ALTHOUGH RESPONDENTS' CLAIMS CANNOT BE CHARACTERIZED AS A CLAIM FOR BENEFITS, RESPONDENTS SUBMIT THAT JUDICIAL REVIEW IS AVAILABLE FOR STATUTORY AND CONSTITUTIONAL CLAIMS EVEN INVOLVING A CLAIM FOR BENEFITS.

Petitioners correctly points out that *Erika* involved statutory claims. Although this issue is not a required holding for Respondents to prevail, it is the position of Respondents that statutory claims which cannot be heard by the carrier are subject to judicial review. Such issues, although rarely meritorious, are easily determined.

Petitioners agree that Congress afforded a forum through 1395u(b)(3) for minor adjudications on individual claims such as arithmetic calculations and the medical necessity of a particular service rendered. In contrast, Petitioners urge that there is no forum to address substantial statutory or constitutional claims. Petitioners' position, if accurate, has the bizarre result of awarding a forum for all claims except those of greatest import. The distinction between those issues justiciable in a Part B hearing for which there is no judicial review and a meritorious statutory claim can be amply demonstrated by the types of cases for which Respondents admit there is no review. Section 1395(y) provides that no payment may be made for services which are not reasonable and necessary for the diagnosis or treatment of illness or injury. Whether a service is medically necessary is left to the carrier under Part B. It is quite another matter, however, should the Secretary or the carrier affirmatively decide not to pay for admittedly medically necessary services. Likewise, whether or not chelation therapy is a reasonable service for the treatment of illness is a matter left to the expertise of the carrier, see *Hertzog, supra*. In

contrast, a flagrant refusal to pay well recognized medical services contemplated by Congress without some form of judicial review would result in an unprecedented granting by Congress of absolute discretion on the part of an agency in conjunction with a private insurance company to comply or choose not to comply with an act of Congress.

To the extent *Erika* addressed this issue, Respondents submit that the full scope of this issue was not reviewed by the Court at that time. In fact, the supplier of services in *Erika* did not point out to the Court the lack of authority on the part of the Part B hearing officer to address statutory claims. Furthermore, the Court's opinion made it clear that the issue of the authority of Congress to limit review for any forum on statutory claims were not properly pressed by Respondent in that case. *Erika*, *supra*, fn. 14.

Contrary to the assertions of Petitioners, this Court has not considered the full import of barring any forum to review statutory claims under Part B.

D. RESPONDENTS' CONSTITUTIONAL CLAIMS ARE SUBSTANTIAL.

Rather than address the issue of Congress' power to bar any forum whatsoever to address statutory and constitutional claims, Petitioners, not having appealed on the merits, now suggests that Respondents' constitutional claims are insubstantial. This statement is offered by Petitioners with no citation to the trial record in support of any rationale they can espouse, no acknowledgement that the lower court did, in fact, deny Petitioners' motion for summary judgment on the constitutional issue, and no admission that Petitioners, in fact, did concede at trial that at least as to board eligible family physicians, Petitioners could offer no rationale for their actions.

In *Hagans* v *Lavine*, 415 U.S. 534 (1974) the Supreme Court considered whether the lower court properly exer-

cised subject matter jurisdiction in a case arising out of the AFDC Program. The district court in *Hagans* had accepted subject matter jurisdiction based upon the constitution allegations made by plaintiffs, but then had resolved the case on a pendent, statutory basis. The Supreme Court approved of the actions of the district court and reaffirmed the "substantiality doctrine" of federal question jurisdiction. The Court noted that since a "substantial" question is necessary to support jurisdiction, the question became whether the allegations made were so attenuated and insubstantial as to be absolutely devoid of merit or whether the claims made were "wholly and substantial", or "wholly insubstantial", "obviously frivolous", "plainly insubstantial", or "no longer open to discussion." *Hagans, supra,* at 415 U.S. 536-7. Even though the case involved a constitutional attack on the field of social welfare, the Supreme Court found the constitutional allegations substantial, noting:

> In *Dandridge* v *Williams*, 397 U.S. 471 . . ., AFDC recipients challenged the Maryland Maximum Grant Regulation on equal protection grounds. We held that the issue should be resolved by inquiry whether the classification had a rational basis. Finding it did, we sustained the regulation. But *Dandridge* evidenced no intention to suspend the operation of the equal protection clause in the field of social welfare law. The state law and regulations must still 'be rationally based and free from invidious discrimination.' 415 U.S. at 539.

The level of judicial scrutiny of legislative or administrative classifications is dependent upon the nature of the classification, the importance of the right being affected by the classification, and the legitimacy of the governmental interest advanced by the classification. Compare *Dandridge, supra, Califano* v *Aznavorian*, 439 U.S. 170 (1978); *Salfi, supra.*

It is interesting that in the cases commonly cited by the government, the underlying rationale for the governmental

policy ultimately upheld was either to reduce costs, facilitate administrative convenience or prevent fraud. Here the evidence at trial was unrebutted that the rationales normally asserted by the government in substantive due process cases were actually defeated by the government's practice in this case.

The evidence at trial again was unrebutted that the multiple screen system exacerbates the maldistribution of physicians, the physician's choice of specialty, and the patient's choice of physicians (Feldstein, D.E. 130 at 11, Joseph Califano, D.E. 135, Exhibit 30 at 9, Robert Derzon, D.E. 135, Exhibit 29).

Petitioners now suggest, without citations to the record, that the regulation in question was promulgated to reflect the already existing marketplace (Pet. Brief at 39). Ironically, the record in this case established that the regulation in question has precisely the opposite effect. The unrebutted testimony in this case was that a single prevailing fee calculation would result in a lower charge per service, render the Medicare Program efficient, and more correctly bring market forces in to play (Feldstein, D.E. 130 at 14). Likewise, the multiple prevailing fee concept has the effect of moving the patient towards more expensive costs for the same service (Feldstein, D.E. 130 at 11). Supporting Feldstein were statements by Joseph Califano, past Secretary of HHS, and Robert Derzon, Administrator of the Health Care Financing Administration. (D.E. 135, Pl. Ex. 29, 30).

Petitioners find themselves in the untenable position of defending a regulation which operates contrary to any stated rationale. It is a little more ironic that Petitioners can concede irrationality at least in part at trial, fail to offer rationale for the regulation at trial, and then insist that the jurisdiction does not exist since no valid constitutional claim can be made. Petitioners failed to appeal on the merits and specifically failed to appeal the denial of summary judgment wherein the lower court found the Respondents' constitutional claim to be substantial.

II. ASSUMING, ARGUENDO, THE MEDICARE STATUTE AUTHORIZES AN AGENCY OF THE FEDERAL GOVERNMENT TO VIOLATE THE MEDICARE STATUTE OR THE FIFTH AMENDMENT WITH NO REDRESS THE STATUTE VIOLATES ARTICLE III AND THE FIFTH AMENDMENT TO THE UNITED STATES CONSTITUTION.

The Constitution provides a basis for Congress to limit the jurisdiction of the lower federal courts and the Supreme Court. The power to create the inferior federal courts, granted in Articles I and III of the Constitution, has been held to imply the power to establish the jurisdiction of those courts. However, the powers granted to Congress in Articles I and III of the Constitution have never been held by this Court to enable Congress to prohibit judicial review of the constitutionality of any act of Congress or any regulation promulgated pursuant thereto. Indeed, such a proposition would entail rethinking the supremacy principle, which has been the underpining of our constitutional system, announced in *Marbury* v *Madison*, 5 U.S. (1 Cranch) 137 (1803).[4]

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[4] Though there has been considerable academic debate over the various intricacies of the power of Congress to limit the jurisdiction of the Supreme Court and the lower federal courts, "all agree that Congress cannot bar all remedies for enforcing federal constitutional rights." Gunther, *Congressional Power To Curtail Federal Court Jurisdiction: An Opinionated Guide To The Ongoing Debate*, 36 STAN. L. REV. 895, 921 note 113. See also, Brilmayer and Anderhill, *Congressional Obligation To Provide A Forum For Constitutional Claims: Discriminatory Jurisdictional Rules And The Conflicts Of Law*, 69 VA. L. REV. 819 (1983); Eisenberg, *Congressional Authority To Restrict Lower Federal Court Jurisdiction*, 83 YALE L.J. 498 (1974); Forkosch, *The Exceptions and Regulations Clause of Article III and a Person's Constitutional Rights: Can the Latter be Limited by Congressional Power Under the Former?*, 72 W. VA. L. REV. 238 (1970); Hart, *The Power of Congress to Limit the Jurisdiction of Federal Courts: An Exercise in Dialectic*, 66 HARV. L. REV. 1362 (1953); Merry, *Scope of the Supreme Court's Appellate Jurisdiction: Historical Basis*, 47 MINN. L. REV. 53 (1962); Ratner, *Congressional Power Over the Appellate Jurisdiction of the Supreme Court*, 109 U. PA. L. REV. 157 (1960); Strong, *Rx for a Nagging Constitutional Headache*, 8 SAN DIEGO L. REV. 246 (1971); Van Alstyne, *A Critical Guide to Ex Parte McCardle*, 15 ARIZ. L. REV. 229 (1973); Wechsler, *The Courts and the Constitution*, 65 COLUM. L. REV. 1001 (1965).

Jurisdictional limitations enacted by Congress are not exceptions to *Marbury* principle. This Court's decisions have consistently scrutinized the constitutionality of jurisdiction limiting acts of Congress. See, e.g. *Yakus* v *United States*, 321 U.S. 414, (1944) (wherein the court notes that Congress has the power "to define the jurisdiction of inferior federal courts and to create such courts for the exercise of a judicial power . . . subject to other constitutional limitations . . ."); and *Johnson* v *Robison, supra*. See also, *United States* v *Klein*, 80 U.S. (13 Wall.) 128 (1872); *Ex parte McCardle*, 74 U.S. (7 Wall.) 506 (1868).

The separation of powers principle embodied in our constitutional framework makes it axiomatic that it is the province of the Court to review actions of both the legislative and executive branches of government for their constitutionality. In *Marbury, supra*, Chief Justice Marshall, writing for the Court, stated as follows:

> It is emphatically the province and duty of the judicial department to say what the law is. Those who apply the rule to particular cases, must of necessity expound and interpret that rule. If two laws conflict with each other, the Court must decide on the operation of each.
>
> So, if a law be in opposition to the constitution; if both the law and constitution apply to a particular case . . . the court must determine which of these conflicting rules governs the case. This is of the very essence of judicial duty. 5 U.S. (1 Cranch) at 177-178 (1903).

This view of *Marbury* was emphatically discussed by this Court in *Cooper* v *Aaron*, 358 U.S. 1, 3 (1958), wherein the Court stated as follows:

> Article VI of the constitution makes the constitution the 'supreme law of the land.' In 1903, Chief Justice Marshall, speaking for a unanimous court, referring to the constitution as the 'fundamental and paramount law of

> the nation,' declared in the notable case of *Marbury* v *Madison*, (U.S.) 1 Cranch 137, 177, 2 L. Ed. 2d 60, 73, that 'It is emphatically the province and duty of the judicial department to say what the law is.' This decision declared the basic principle that the federal judiciary is supreme in the expedition of the law of the constitution, and that principle has ever since been respected by this Court and the country as a permanent and indispensable feature of our constitutional system.
> 358 U.S. at 17-18.

This Court has long held that a "person asserting a right, whatever its source, should be entitled to the independent judgment of a court on the ultimate question of constitutionality." *St. Joseph Stockyards Co.* v *U.S.*, 298 U.S. 38, 84 (1936). (Brandeis, J. concurring). The right to such judicial review goes beyond constitutional claims, such as made in this case. For example, in *Addison* v *Holly Hill Fruit Products*, 322 U.S. 607 (1944), this Court discussed the right to judicial review regarding administrative regulation. Therein, the Court noted that the "determination of the extent of authority given to a delegated agency by Congress is not left for the decision of him in whom authority is vested." 322 U.S. at 616. That case clearly stands for the proposition that where, as in the present case, there is a question as to whether a regulation goes beyond the extent of power delegated by Congress, the litigant is entitled to a judicial determination of the issue. See also, *United States* v *Vogel Fertilizer Company*, 455 U.S. 16 (1982), (wherein the court struck down a treasury regulation noting that it was not a "reasonable statutory interpretation").

Another case discussing the duty of Congress to provide a forum for claims is *Yakus* v *U.S.*, *supra*.[5] *Yakus* involved a criminal action against an individual for allegedly violating the wartime Emergency Price Control Act of January 30, 1942. The statute set up a procedure whereby individuals affected could challenge regulations issued pursuant to the act through an administrative review process, together with appellate rights to an energency Court of Appeals organized by Congress and with review by the Supreme Court on writ of certiorari.[6] The petitioners in *Yakus* were individuals who were convicted of criminally violating the Emergency Price Control Act. They attempted to challenge the validity of the act and regulations in their criminal cases, but were denied the opportunity to do so, the lower courts noting that they had failed to use the mechanisms organized by the act for such challenges. The Supreme Court upheld the rulings of the lower court noting that the statute provided adequate opportunity for the petitioners to have challenged the validity of the act and regulations. The court noted that the statute provided full due process rights to the petitioners:

> The organization of such an exclusive procedure especially adapted to the exigencies and requirements of a nation-wide scheme of price regulation is, as we have seen, within the constitutional power of Congress to create inferior federal courts and prescribe their jurisdiction.

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[5] See Hart, *The Power of Congress To Limit The Jurisdiction Of Federal Courts: An Exercise In Dialectic*, 66 HARV. L. REV 1362 (1953), wherein Professor Hart notes that "[s]hutting of the courts from questions of law determinative of enforceable duties was one of the things *Yakus* assumed that Congress could not do." In Professor Hart's dialogue, he includes the following colloquy:

> Name me a single Supreme Court case that has squarely held that, in a civil enforcement proceeding, questions of law can be validly withdrawn from the consideration of the enforcement court where no adequate opportunities to have them determined by a court has previously been accorded. When you do, I am going back to rethink *Marbury* v *Madison*. Hart, at 1378-79

[6] The process set up by this statute was found to be constitutional in *Lockerty* v *Phillips*, 319 U.S. 182 (1943).

* * *

> Such a procedure, so long as it affords those affected a reasonable opportunity to be heard and present evidence does not offend due process. [Citations omitted.]
>
> * * *
>
> The Emergency Court has power to review all questions of law, including the question whether the administrators determination is supported by evidence, and any questions of the denial of due process or any procedural error appropriately raised in the course of the proceedings. No reason is advanced why petitioners could not, throughout the statutory proceeding, raise and preserve any due process objection to the statute, the regulations, or the procedure, and secure its full judicial review by the Emergency Court of Appeals and this Court.
>
> * * *
>
> There is no constitutional requirement that the test of the validity of regulations, or administrative action be made in one tribunal rather than in another, so long as there is an opportunity to be heard and for judicial review which satisfies the demands of due process, as is the case here. 321 U.S. at 433-444.

Yakus upheld the exercise of Congress' wartime powers in enacting the Emergency Price Control Act noting that Congress had fulfilled its obligation to provide a forum in which those affected by the regulations could challenge their validity. *Yakus*, despite its provisions for a forum in which to challenge regulations, has been viewed as an unusual decision, rendered during a war time emergency. *Ademo Wrecking Co.* v *United States*, 434 U.S. 275, (1978) (Justice Powell, concurring). Justice Powell, in his concurring opinion, cited the brief for the United States in *Yakus* noting that the government argued that the statute should be upheld under the war powers authority of Congress. It was noted that war time emergency could justify "the shortcutting of

normal due process rights." 434 U.S. at 290.

In contrast, the present case is postured, as the Sixth Circuit noted, such as "[i]n the absence of federal question jurisdiction, therefore, the Secretary would have unbridled discretion to promulgate any regulation he chose." (Pet. App. at 10a).[7]

Recent decisions of this Court also stress the requirement for a proper forum in which litigants can press their claims. In *Northern Pipeline Construction Co.* v *Marathon Pipeline Company*, 480 U.S. 50 (1982) this Court held, in a plurality opinion, that the Bankruptcy Reform Act's broad grant of jurisdiction to bankruptcy judges providing "jurisdiction of all civil proceedings arising under Title 11 or arising in relation to cases under Title 11," violated Article III of the Constitution. Citing *Crowell* v *Benson*, 285 U.S. 22 (1932) and *United States* v *Raddatz*, 447 U.S. 667 (1980), the Court noted that Congress may not assign "essential attributes of the judicial power" to non-Article 3 courts or administrative bodies. The Court noted that in *Raddatz*, *supra*, it sustained the use of an adjunct fact finder for constitutional claims, "so long as the adjuncts were subject to sufficient control by Article III district court." 478 U.S. 78-79. The court in *Raddatz* upheld the 1978 Federal Magis-

[7] The above rule, of course, is necessary to avoid an impermissible delegation to a private party of adjudicatory functions. It has long been held that governmental agencies may only assign limited duties to private agencies. See, e.g., *Nassau Securities Service* v *Securities and Exchange Commission*, 348 F. 2d 133 (2d Cir. 1965), (holding that it was permissible to assign certain administrative duties to a private party relating to securities regulation where the action of the private party is subject "to full review by the Securities Exchange Commission, a wholly public organ, with a hearing before it if requested, the taking of further evidence it may deem relevant, and a decision based on its own findings."); and *New Motor Vehicle Board Of California* v *Orrin W. Fox Co.*, 439 U.S. 96 (1978), (indicating that under limited circumstances administrative duties may be assigned to private parties). No cases decided by this Court or any other federal court have held that questions relating to the legality of regulations, including statutory and constitutional questions, may be delegated to a private party (such as the Medicare carrier in this case) without access to judicial review.

trates Act, which permitted district judges to refer certain pretrial motions to magistrates, but provided for de novo review by the district court. The lead opinion of this Court in *Northern Pipeline* cited favorably the edict of *Crowell* relating to the essential functions of the judicial power. In pertinent part, the lead opinion states as follows:

> But while *Crowell* certainly endorsed the proposition that Congress possesses broad discretion to assign fact-finding functions to an adjunct created to aid in the adjudication of Congressionally created statutory rights, *Crowell* does not support the further proposition necessary to appellant's argument— that Congress possess the same degree of discretion in assigning traditionally judicial power to adjuncts engaged in the adjudication of rights *not* created by Congress. (Emphasis in original) Indeed, the validity of this proposition was expressly denied in *Crowell*, when the court rejected 'the untenable assumption that the constitutional courts may be deprived in all cases of the determination of facts upon evidence even though a *constitutional* right may be involved', 285 U.S. at 60-61, 52 S. Ct. at 296 (emphasis in original) [Footnote omitted] and stated that
>
> > 'The essential independence of the exercise of judicial power of the United States in the enforcement of *constitutional* rights requires that the federal court should determine . . . an issue [of agency jurisdiction] upon its own record and the facts solicited before it.' Id. at 64, 52 S. Ct. at 297 (emphasis and parenthetical statement in original).
>
> 458 U.S. at 83-84

The Court in *Northern Pipeline* further commented on the requirement that, under any act of Congress, the "essential attributes of the judicial power" may not be removed from Article III courts. Acts of Congress that attempt to restrict judicial review pertaining to functions that have been traditionally performed by the Judiciary

"cannot be characterized merely as incidential extension of Congress' power to define rights that it has created." 458 U.S. at 84. The plurality opinion noted that such action on the part of Congress would be an unwarranted encroachment "upon the judicial power of the United States, which our Constitution reserves for Art. III courts." 458 U.S. at 84.

Many of the recent directives of this Court have also noted the requirement that Congress must provide a mechanism whereby litigants can assert statutory and constitutional claims to avoid the unconstitutionality of the statute itself. For example, in *South Carolina* v *Regan*, ____ U.S. ____, 104 S. Ct. 1007 (1984), the plaintiff invoked the original jurisdiction of the Supreme Court pursuant to Section 2 of Article III of the United States Constitution. The defendant objected on the grounds that the Anti-Injunction Act, 26 U.S.C. Section 7421(a), prohibited judicial review of the claims made by the plaintiff. The court noted that it would not construe the statute to preclude the action where "Congress has not provided the plaintiff with an alternative legal way to challenge the validity" of the law at issue. See also, *Harrison* v *PPG Industries, Inc.*, 446 U.S. 578 (1980), and *Block* v *Community Nutrition Institute*, ____ U.S. ____, 104 S. Ct. 2450 (1984) (indicating that judicial review of milk market orders issued by the Secretary of Agriculture under the authority of the Agricultural Marketing Agreement Act of 1937 were subject to judicial review in relation to proceedings brought by handlers in accordance with the statute, after following administrative procedures, but unavailable to individual consumers of milk, whose interests were represented by the handlers).

By way of summary then, there is no authority whatsoever that would support the position urged by the Petitioners whereby the Respondents may not have any review whatsoever of their statutory and constitutional claims. The basic principles of due process require a rejection of the

Petitioners' contentions. If the court accepts Petitioners' contention that judicial review of both Plaintiffs' statutory and constitutional claims is precluded by the statute, the statute would, as a matter of necessity, be unconstitutional under authority of the cases discussed above. Congress cannot legislate away Respondents' due process rights and rights to a competent forum in which to assert their statutory and constitutional claims.

CONCLUSION

The judgment of the Court of Appeals should be affirmed.

Respectfully submitted,

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No. 85-225

In the Supreme Court of the United States

OCTOBER TERM, 1985

OTIS R. BOWEN, SECRETARY OF HEALTH AND HUMAN SERVICES, ET AL., PETITIONERS

v.

MICHIGAN ACADEMY OF FAMILY PHYSICIANS, ET AL.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

REPLY BRIEF FOR THE PETITIONERS

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REPLY BRIEF FOR THE PETITIONERS

Respondents contend that the district court had jurisdiction in this case to review one aspect of the determination by the carrier of the amount of benefits payable for certain physicians' services under the Part B Medicare Program. However, as we have explained in our opening brief, judicial review of such matters is foreclosed by two separate provisions of the Social Security Act, 42 U.S.C. 1395ff and 405(h). Respondents' arguments for avoiding these statutory preclusions of review already have been rejected by this Court in *United States* v. *Erika, Inc.*, 456 U.S.

201 (1982), and *Heckler* v. *Ringer*, No. 82-1772 (May 14, 1984).

1. Respondents argue (Br. 23-32) that 42 U.S.C. 1395ff does not foreclose review of "statutory" questions arising in connection with the determination of the amount of benefits payable under the Part B Program. They contend that Section 1395ff bars judicial review only of those issues (essentially factual in nature) that are within the authority of the carrier hearing officer to resolve in the "fair hearing" required by 42 U.S.C. 1395u(b)(3)(C), and that a court therefore may exercise jurisdiction under 28 U.S.C. 1331 to consider legal issues relating to the carrier's benefit determinations under the Part B Medicare Program. However, as respondents appear to concede (Br. 32-33), these very arguments were squarely presented and unanimously rejected in *Erika*.

a. In *Erika*, the plaintiff challenged the carrier's calculation of the prevailing charge for particular Part B services. That prevailing charge, which places a ceiling on the amount of benefits that may be paid for covered services (42 U.S.C. 1395u(b)(3); 42 C.F.R. 405.502; see Pet. Br. 6), is to be established at the level that "would cover 75 percent of the customary charges made for similar services in the same locality during the last preceding calendar year" (42 U.S.C. 1395u(b)(3)). In *Erika*, the plaintiff contended that the carrier's calculation of the prevailing charge level as of one fixed date in the preceding calendar year, without taking into account subsequent price increases, violated the requirement in the language just quoted that the prevailing charge level reflect the customary charges made "during" the preceding year. The Court of Claims held that it had jurisdiction to consider this "statutory" challenge to

the carrier's method of determining the amount of benefits (*Erika, Inc.* v. *United States*, 634 F.2d 580, 585-588 (Ct. Cl. 1980)); concluded that the carrier's approach was inconsistent with the statute (*id.* at 588-589); and remanded the case to the carrier to recalculate the prevailing charge level in a manner consistent with the court's interpretation of 42 U.S.C. 1395u(b)(3) (634 F.2d at 589, 591). See 456 U.S. at 205-206. This Court, however, unanimously reversed, holding that 42 U.S.C. 1395ff completely barred the Court of Claims from exercising jurisdiction in the case. 456 U.S. at 206-211.

Like the plaintiff in *Erika*, respondents challenge the carrier's determination of the prevailing charge level that establishes a ceiling on the amount of benefits payable for particular Part B services. The only difference is that respondents contend that the carrier's approach is inconsistent with the statutory requirement that the services on the basis of which the prevailing charge is calculated be "similar," while the plaintiff in *Erika* argued that the carrier's determination was inconsistent with the requirement that such similar services have been rendered "during" the preceding calendar year. This difference has no bearing on the availability of judicial review, and *Erika* therefore controls here.

b. Moreover, the arguments presented to this Court in *Erika* were precisely those that respondents now advance in this case. The respondent in *Erika* argued that Section 1395ff does not bar judicial review of "statutory" challenges to "administrative actions which might have an effect on the benefit determinations" (*Erika* Resp. Br. at 26), even though it conceded that Section 1395ff does bar review of the carrier's factual determinations. See generally *Erika*

Resp. Br. at I, 6-7, 26-28, 40-41. Essentially identical arguments were made in a brief amicus curiae filed by the American Academy of Family Physicians, the parent organization of the Michigan Academy of Family Physicians, a respondent in this case (see Resp. Br. 2). The family physicians' brief argued that 42 U.S.C. 1395ff should not be construed to bar judicial review of regulatory and statutory questions, even if review of the carrier's essentially arithmetic computation of benefit amounts is foreclosed (*Erika* Amicus Br. at 12-13, 15-18, 23, 25-27), and it cited the district court's decision in the instant case as an example of the sort of statutory challenge to a carrier's actions that, like the claim in *Erika* itself, should not be barred from judicial review under Section 1395ff (*Erika* Amicus Br. at 28). In addition, the American Academy of Family Physicians pointed out that under governing regulations and the Carrier's Manual,[1] the carrier hearing officer is bound by provisions of the Medicare Act, implementing regulations, and instructions issued by the Health Care Financing Administration; and it argued that 42 U.S.C. 1395ff should not be construed to bar judicial review of any such issues that the hearing officer does not have authority to pass upon. See *Erika* Amicus Br. at 14-17. Respondents repeatedly make this same argument in this case. See Resp. Br. 4-5, 16-17, 19, 24-25, 26, 28, 29, 30.[2]

This Court unanimously rejected these arguments in *Erika*, and they are no more persuasive now.

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[1] See 42 C.F.R. 405.860; Department of Health and Human Services, *Medicare Part B Carrier's Manual* § 12016, quoted at Resp. Br. 4-5.

[2] However, the court of appeals in this case did not rest its jurisdictional ruling on the scope of the carrier hearing officer's discretion; the court did not even mention that point. See Pet. App. 6a-11a, 17a-22a.

Nothing in the text or legislative history of 42 U.S.C. 1395ff suggests a congressional intent to distinguish, for purposes of judicial review, between issues of fact on the one hand and issues of statutory construction and the validity of regulations on the other. Section 1395ff provides for judicial review pursuant to 42 U.S.C. 405(g) of the "amount of benefits" payable under Part A of the Medicare Program, but does not provide for such review of the "amount of benefits" under Part B. Section 405(g) in turn specifically provides for judicial review of the validity of regulations issued by the Secretary that have a bearing on the decision on an individual claim for benefits,[3] and the legislative history of 42 U.S.C. 405(g) makes clear that it was intended to establish the mechanism for obtaining judicial review of other questions of law that may be involved in individual claims.[4] Accordingly, when Congress affirmatively authorized judicial review of the amount of benefits under Part A pursuant to 42 U.S.C. 405(g), it thereby authorized judicial review of questions of law, including the validity of regulations issued by the Secretary, that relate to the Secretary's calculation of the amount of benefits. The corresponding *foreclosure* of judicial review of the "amount of benefits" under Part B, which this Court recognized in *Erika*, therefore also extends to questions of statutory construction and the

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[3] Section 405(g) provides in part: "[W]here a claim has been denied by the Secretary * * * because of failure of the claimant * * * to submit proof in conformity with any regulation prescribed under subsection (a) of this section, the court shall review only the question of conformity with such regulations and the validity of such regulations."

[4] See H.R. Rep. 728, 76th Cong., 1st Sess. 43 (1939); S. Rep. 734, 76th Cong., 1st Sess. 52 (1939).

validity of regulations that may affect the carrier's determination of the amount of benefits payable under Part B.

It does not matter for these purposes that, as respondents repeatedly stress, the carrier hearing officer is bound to follow the provisions of the Act, implementing regulations, and instructions issued by the Secretary. Compare *Ringer*, slip op. 4. This requirement simply reflects the practical necessity that the Secretary must retain ultimate administrative responsibility for legal issues that arise in connection with the adjudication of claims under the vast Part B Medicare Program and that the carrier's personnel are not free to disagree with his resolution of these matters. The purpose of an administrative hearing is not to resolve such questions of law in any event, especially since they do not turn on circumstances unique to a particular claimant. See *Heckler* v. *Campbell*, 461 U.S. 458, 467-468 (1983). The provisions of the regulations and Carrier's Manual limiting the authority of the carrier hearing officer with respect to questions of law therefore have no bearing whatsoever on the availability of judicial review of such questions. Cf. *Schweiker* v. *McClure*, 456 U.S. 188, 197 (1982).[5]

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[5] Contrary to respondents' apparent contention (Resp. Br. 24), the carrier hearing officer in *Erika* held that the issues involved in that case—whether retroactive adjustments could be made in the reimbursement for certain supplies and whether the prevailing charge level could be adjusted upward to account for price increases during the year—were beyond his authority to determine, in light of instructions from the Secretary that prohibited such adjustments. *Erika* Pet. App. at 46a-48a, 78a-86a. In fact, the hearing officer specifically cited the regulation (42 C.F.R. 405.860) that required him to follow the provisions of the Act, regulations, and instructions. *Erika* Pet. App. at 40a.

Thus, as this Court recently observed, in distinguishing *Erika* from a case in which Congress was held not to have foreclosed judicial review of statutory questions relating to benefit determinations, the circumstances of the enactment of 42 U.S.C. 1395ff " 'confirm[ed]' Congress' intent *absolutely* to preclude review." (*Lindahl* v. *OPM*, No. 83-5954 (Mar. 20, 1985), slip op. 21 n.28 (emphasis added), quoting *Erika*, 456 U.S. at 208). The Court followed *Erika* only two years ago in *Ringer*, holding that a statutory challenge to the carrier's actions and the validity of a formal ruling by the Secretary was foreclosed under Part B. *Ringer*, slip op. 5 n.4, 6-7 & n.7. Moreover, since *Erika* was decided, Congress has revisited the Part B Medicare Program on numerous occasions and made extensive revisions in that Program.[6] But although proposals have been made to provide for judicial review under Part B in certain circumstances, Congress has not amended 42 U.S.C. 1395ff to overrule *Erika* and provide for even limited judicial review of such matters. Compare *Merrill Lynch, Pierce, Fenner & Smith* v. *Curran*, 456 U.S. 353, 381-382 (1982).[7] There accordingly is no basis

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[6] See Pub. L. No. 97-248, §§ 104(a), 113(a), 128(d)(1), 96 Stat. 336, 340, 367; Pub. L. No. 98-369, §§ 2306, 2339, 98 Stat. 1070, 1093; Pub. L. No. 98-617, § 3(a)(1), (b)(5) and (6), 98 Stat. 3295-3296; Pub. L. No. 99-107, § 5(b), 99 Stat. 479.

[7] On September 11, 1985, the House Committee on Energy and Commerce reported a bill that would amend 42 U.S.C. 1395ff to provide for an ALJ hearing on a Part B claim if the amount in controversy is $500 or more and judicial review if the amount in controversy is $1000 or more. H.R. 3101, 99th Cong., 1st Sess. § 132. See H.R. Rep. 99-265, 99th Cong., 1st Sess. 51 (1985). This provision then was included as Section 9212 of H.R. 3128, 99th Cong., 1st Sess. (1985) (the

for respondents' contention that the Court should now recognize a right of judicial review where it previously held such review to be barred in *Erika*—and to do so without regard to the amount-in-controversy and other limitations on judicial review under 42 U.S.C. 1395ff and 405(g), as the court of appeals permitted in this case.[8]

Consolidated Omnibus Budget Reconciliation Act of 1985). See 131 Cong. Rec. H13125 (daily ed. Dec. 19, 1985). That bill was reported by the Conference Committee on December 19, 1985 (*id.* at H13093), but the House and Senate are in disagreement concerning approval of the Conference Report. See *id.* at H13302, S18400-S18401.

The portions of the committee reports discussing the Medicare appeal provisions make clear that Congress is of the view that, at the present time, "[t]he law does not provide for any * * * judicial review for a [P]art B claim." H.R. Conf. Rep. 99-453, 99th Cong., 1st Sess. 452-453 (1985), *reprinted in* 131 Cong. Rec. H13238 (daily ed. Dec. 19, 1985); H.R. Rep. 99-265, *supra*, at 51-52. See also *Health Financing: Hearings on Deficit Reduction Proposals—Part B of Medicare, Before the Subcomm. on Health and the Environment of the House Comm. on Energy and Commerce*, 99th Cong., 1st Sess. 476 (1985) (discussing *Erika*); *id.* at 427, 458, 472-493, 531.

[8] The suggestion by respondents (Br. 26-27) and amicus American Medical Association (AMA Br. 7-8, 11) that *Erika* is distinguishable because this case does not involve an actual claim for benefits is completely without merit. Respondents stress (Br. 27) that all the court of appeals did was to remand the case to the Secretary with instructions to determine the prevailing charge by reference to "similar" services, and that it did not become involved in the adjudication of particular benefit claims. Respondents ignore the fact that this also was the only relief granted by the Court of Claims in *Erika*; the court there likewise eschewed any role in the determination of individual claims. 634 F.2d at 589-591; see 456 U.S. at 206.

In addition, although respondents have not sought an actual award of benefits from the courts in this case, they have sought judicial review of a regulation that pertains to

2. Respondents make only a passing effort (Br. 20-23) to avoid the force of 42 U.S.C. 405(h), which is incorporated into the Medicare Program by 42 U.S.C. 1395ii and independently bars judicial review in this case. The second sentence of Section 405(h) provides that "no findings of fact or decision of the Secretary shall be reviewed by any * * * tribunal * * * except as herein provided"—*i.e.*, except as provided in the Social Security Act itself. Because nothing in the Social Security Act provides for judicial review under Part B, such review is foreclosed by the second sentence of Section 405(h). Respondents argue (Br. 21) that the second sentence of Section 405(h) does not apply in this case because decisions on claims for benefits under Part B are made by the carriers, not the Secretary. See also AMA Br. 13-14. This argument, however, ignores the fact that the carrier simply acts as the Secretary's agent in adjudicating Part B claims, and the Secretary is the real party in interest in any litigation arising under the program. See *Erika*, 456 U.S. at 206 n.4. Respondents' argument is especially misplaced in this case,

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the prevailing charge aspect of benefit determinations, which is an integral part of a claim for benefits under Part B. A claimant cannot avoid the total preclusion of review under 42 U.S.C. 1395ff by splitting off one legal issue that may have a bearing on his claim for benefits and seeking judicial review on only that discrete matter. See *Ringer*, slip op. 5 n.4, 12, 18-19. Moreover, in *Erika*, the carrier hearing officer applied what he understood to be binding instructions from the Secretary that limited the amount of reimbursement. *Erika* Pet. App. at 44a-46a, 80a-82a. The Court of Claims reviewed several of those instructions, and determined that they were not binding. 634 F.2d at 590-591. Thus, contrary to the AMA's assertion (AMA Br. 8 n.4), *Erika* cannot be distinguished on the ground that it did not involve a challenge to instructions issued by the Secretary.

because they brought this suit to challenge a regulation promulgated by the *Secretary* that allows separate prevailing charge screens.

The third sentence of Section 405(h), as incorporated by 42 U.S.C. 1395ii, provides that "[n]o action" shall be brought under 28 U.S.C. 1331 "to recover on any claim arising under" the Medicare Act. Respondents first maintain (Br. 21) that this sentence is inapplicable in this case because they are not seeking to recover on a claim for benefits, but instead are challenging the mechanism for determining the prevailing charge level. However, as we have explained (Pet. Br. 6, 24-25), the prevailing charge level is an integral component in the determination of the amount of benefits payable on a particular claim. Accordingly, contrary to the AMA's assertion (AMA Br. 17), respondents' challenge to the prevailing charge level is "inextricably intertwined" with the claim for benefits. Under *Ringer* (slip op. 11-13, 19-23), a claimant cannot separate out one issue bearing on his claim for benefits in this manner and seek judicial review of that issue in a separate action under 28 U.S.C. 1331. See Pet. Br. 35-36.

Respondents next argue (Br. 22-23) that the third sentence of Section 405(h) does not bar this suit under 28 U.S.C. 1331 because review is not otherwise available under 42 U.S.C. 405(g). However, in *Ringer*, this Court explicitly rejected the contention that the application of the sweeping jurisdictional bar in Section 405(h) depends on whether Congress has authorized judicial review under another provision of the Social Security Act. *Ringer*, slip op. 19. Indeed, the very purpose of Section 405(h) is to preclude judicial review except where and to the extent it is affirmatively authorized under the Social Se-

curity Act, pursuant to 42 U.S.C. 405(g). S. Rep. 734, *supra*, at 52; H.R. Rep. 728, *supra*, at 43-44.[9] Thus, Section 405(h) reinforces what is in any event clear from the text and legislative history of 42 U.S.C. 1395ff: judicial review of the carrier's determination of the prevailing charge level in this case is foreclosed.

3. Although it is not directly involved here, respondents also present (Br. 7-12, 33-34) a defense of the court of appeals' holding on the merits. The court of appeals held that the regulation authorizing the establishment of separate charge screens (42 C.F.R. 405.504(b)) is inconsistent with the requirement in 42 U.S.C. 1395u(b)(3) that the prevailing charge level be calculated on the basis of charges for

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[9] Contrary to the AMA's contention (AMA Br. 17-19), the fact that Congress, in 42 U.S.C. 1395ii, provided that Section 405(h) and certain other provisions of Title II shall apply to the Medicare Program "to the same extent as they are applicable with respect to [title] II" does not suggest that Section 405(h) has a less sweeping application under the Medicare Program. To the contrary, Congress made Section 405(h) applicable "to the same extent" as under Title II, where it absolutely bars the exercise of jurisdiction under 28 U.S.C. 1331 and permits judicial review only pursuant to 42 U.S.C. 405(g). See *Weinberger* v. *Salfi*, 422 U.S. 749, 756-762 (1975). Congress provided for judicial review pursuant to 42 U.S.C. 405(g) under the Medicare Act in certain circumstances. See 42 U.S.C. 1395ff. It therefore is reasonable to assume that Congress intended Section 405(h) to have the effect under the Medicare Act, as under Title II, of barring the exercise of jurisdiction under 28 U.S.C. 1331 and to allow judicial review only where it is affirmatively authorized by 42 U.S.C. 1395ff and 405(g). Moreover, the Court enforced the preclusion of review in Section 405(h) in *Ringer*, a Medicare case, without suggesting that it does not apply with full force under the Medicare Program. See *Ringer*, slip op. 11-12, 19-23.

"similar" services (Pet. App. 11a-14a). Respondents' arguments warrant a brief response.

Respondents' submission proceeds as if the decision by the carrier in Michigan to adopt separate charge screens is an aberration under the Medicare Program. In fact, however, separate screens for specialists and general practitioners are the rule, not the exception. A study prepared for the responsible congressional committees in 1983 stated that in the period between July 1, 1981 and June 30, 1982, "Medicare carriers recognized specialty reimbursement differentials in all areas of the country except for Florida, Kansas, North Dakota, South Dakota, and the area of New York served by Blue Shield of Western New York." Staffs of the Sen. Comm. on Finance and the House Comms. on Ways and Means and Energy and Commerce, 98th Cong., 1st Sess., *Background Data on Physician Reimbursement Under Medicare* 74 (Joint Comm. Print 1983) [hereinafter cited as Comm. Print].[10] There was no suggestion that these differing charge screens are unlawful under 42 U.S.C. 1395u, as respondents maintain. See Comm. Print 10, 95-96.

Moreover, although Congress has extensively revised the Part B physician reimbursement provisions in 42 U.S.C. 1395u in a number of respects in recent years (see page 7 and note 6, *supra*), Congress has

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[10] The study states: "Differentials between general practitioners and specialists were already recognized by many private insurance plans at the time Medicare was enacted. Over the years there has been some concern that the general policy among third parties, including Medicare, of recognizing such fee differentials has tended to encourage increased specialization. However, it has been suggested by some that specialists may provide a different type of higher quality service." Comm. Print 74.

not amended that Section to prohibit the use of separate charge screens, which have been authorized by the Secretary's regulations since 1967.[11] To the contrary, in Section 2309 of the Deficit Reduction Act of 1984, Pub. L. No. 98-369, 98 Stat. 1074-1075, Congress directed the Office of Technology Assessment to "conduct a study of physician reimbursement under the medicare program"; this study is to include findings and recommendations regarding how "payment amounts and other program policies under part

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[11] The regulation already was in effect in 1972, when Congress amended 42 U.S.C. 1395u to add the sentence under which respondents now argue that the regulation is invalid. See 20 C.F.R. 405.504(b) (1972); Pub. L. No. 92-603, § 224(a), 86 Stat. 1395. That sentence provides that no charge shall be found to be reasonable if it exceeds "the prevailing charge level that, on the basis of statistical data and methodology acceptable to the Secretary, would cover 75 percent of the customary charges made for similar services in the same locality during the last preceding calendar year * * *." This sentence was incorporated essentially verbatim from, and was intended to ratify, a provision in the then-existing regulations that placed a limit on the reasonable charge. See S. Rep. 92-1230, 92d Cong., 2d Sess. 191-194 (1972). The regulatory provision Congress incorporated into the Act was subsection (a) of 20 C.F.R. 405.504 (1972). Subsection (b) of that same regulation contained the authorization for separate charge screens that respondents challenge in this case. Accordingly, Congress must have been aware when it enacted the amendments in 1972 that the use of separate charge screens was a "methodology acceptable to the Secretary" within the meaning of subsection (a) of the regulation and, therefore, within the meaning of the sentence it added to 42 U.S.C. 1395u. Congress's failure to amend 42 U.S.C. 1395u to prevent the use of separate charge screens in these circumstances thus lends considerable support to the reasonableness of the Secretary's interpretation of the Act as permitting the use of such screens. Compare *Merrill Lynch, Pierce, Fenner & Smith* v. *Curran*, 456 U.S. at 381-382.

B * * * may be modified" to, inter alia, "eliminate inequities in the relative amounts paid to physicians by type of service, locality, and *specialty*" (§ 2309 (a)(1)(A) (emphasis added)).[12] There is no suggestion in this legislation that any differences in the relative amounts paid to physicians depending upon their specialty was any less consistent with the Act than differences that might occur as a result of "type of service" or "locality." See H.R. Conf. Rep. 98-861, 98th Cong., 2d Sess. 1318-1319 (1984). Congress simply chose to study the matter to determine whether possible adjustments should be made in the established reimbursement scheme. Compare *Heckler* v. *Day*, No. 82-1371 (May 22, 1984), slip op. 9-10.

Against the background of Congress's close scrutiny of the Medicare Part B Program and its frequent amendments to the governing statutory provisions, it was an "unwarranted judicial intrusion into this pervasively regulated area" (*Day*, slip op. 15) for the court of appeals to invalidate a reimbursement method that has been a feature of the Part B Program virtually since its enactment.

4. Finally, respondents argue (Br. 32-34) that the regulation authorizing the use of different charge screens based on a physician's specialty violates the Due Process Clause, and they contend (Br. 35-43) that Congress cannot foreclose judicial review of that contention. However, for the reasons stated in our opening brief (at 43-44), respondents' constitutional arguments are too insubstantial to support subject matter jurisdiction. See *Ringer*, slip op. 5 n.4. Respondents cite (Br. 34) testimony by several wit-

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[12] The report was to be submitted to Congress by December 31, 1985 (98 Stat. 1075), but we have been informed that it has not yet been completed.

nesses in this case to the effect that the use of separate charge screens causes more physicians to become specialized, affects a patient's choice of a physician, and leads to increased costs. Even if this testimony is credited, neither the Medicare Act nor an implementing regulation is unconstitutional because it may have those incidental consequences.

The purpose of the Medicare Act is to provide a program of insurance for a portion of the reasonable medical charges actually incurred by a beneficiary, based on experience in the community. It therefore plainly is rational for Congress, through the Secretary, to authorize carriers to utilize differing charge screens based on existing differentials in the charging patterns of specialists and others. Moreover, Congress rationally could determine that services furnished by persons with certain types of specialization are sufficiently different from comparable services furnished by others to warrant different levels of reimbursement. The question in respondents' constitutional challenge to the regulation is not whether Congress (or even the Secretary or the carrier) has current empirical data to establish the validity of these premises. The question is whether Congress rationally could have believed them to be valid. *Vance* v. *Bradley*, 440 U.S. 93, 109-112 (1979). Respondents have made no showing whatever that Congress could not rationally do so.[13]

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[13] Respondents and the AMA suggest (Br. 35, 37; AMA Br. 19-25) that, under the three-part balancing test of *Mathews v. Eldridge*, 424 U.S. 319, 335 (1976), the Due Process Clause requires the availability of judicial review even in the absence of a constitutional question. This contention was not raised by respondents in the court of appeals, and it is, in any event, without merit. This Court, applying the three-part balancing test of *Mathews* v. *Eldridge, supra*,

For the foregoing reasons and the additional reasons stated in our opening brief, the judgment of the court of appeals should be reversed.

Respectfully submitted.

CHARLES FRIED
Solicitor General

JANUARY 1986

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already has rejected the contention that the Due Process Clause prevents Congress from according finality to the carrier's determination of Part B Medicare claims. *Schweiker* v. *McClure*, 456 U.S. at 198-200. Nor has this Court elsewhere suggested that it would be unconstitutional for Congress to foreclose judicial review of nonconstitutional issues that might arise in connection with the adjudication of claims for statutory benefits. See *Johnson* v. *Robison*, 415 U.S. 361, 366-367 (1974); *Salfi*, 422 U.S. at 762; *Lindahl* v. *OPM*, slip op. 8-21. Compare *Northern Pipeline Co.* v. *Marathon Pipe Line Co.*, 458 U.S. 50, 77-87 (1982) (plurality opinion).

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No. 85-225

IN THE

Supreme Court of the United States

OCTOBER TERM 1985

MARGARET M. HECKLER, SECRETARY OF HEALTH AND HUMAN SERVICES, et al.,

Petitioners

v.

MICHIGAN ACADEMY OF FAMILY PHYSICIANS, et al.,

Respondents

On Writ of Certiorari to the United States Court of Appeals For the Sixth Circuit

BRIEF AMICUS CURIAE OF THE AMERICAN MEDICAL ASSOCIATION IN SUPPORT OF RESPONDENTS

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QUESTIONS PRESENTED

Amicus American Medical Association will address the following issues:

1. Whether 42 U.S.C. §1395ff or 42 U.S.C. §405(h), to the extent incorporated in 42 U.S.C. §1395ii, bars federal jurisdiction under 28 U.S.C. §1331 of a general challenge to the statutory and constitutional authority of the Secretary of Health and Human Services to promulgate a regulation, when no other basis for judicial review of the lawfulness of that regulation exists.

2. Whether judicial review of the question whether the Secretary of Health and Human Services has promulgated a regulation which exceeds the scope of his delegated authority is constitutionally required to satisfy the demands of due process and maintain the constitutional scheme of separation of powers.

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BRIEF AMICUS CURIAE OF THE AMERICAN MEDICAL ASSOCIATION IN SUPPORT OF RESPONDENTS

INTEREST OF AMICUS CURIAE

The American Medical Association ("AMA") offers this brief as amicus curiae in support of respondents.[1] Founded in 1846, the AMA is a private, voluntary nonprofit organization of physicians. Its purpose has always been to promote the science and art of medicine and to improve the public health. Its membership exceeds 234,700 physicians and medical students.

Respondents have alleged that the Medicare Act has been violated by 42 C.F.R. §405.504, a regulation of the Secretary of Health and Human Services ("the Secretary") under Part B of the Act. The Secretary takes the position that no court is empowered even to consider respondents' challenge to the regulation. Thus, this case raises the question of whether an association of physicians can obtain judicial review of an across-the-board regulation involving Part B of Medicare.

The AMA has a direct and substantial interest in this question. Specifically, it is most concerned that the federal courts will be available to review the lawfulness of Medicare regulations which may affect access to or quality of medical care. If the courts are not open, the statutory and other legal guaranties which have until now generally protected the rights of physicians and their patients under the Medicare program will be illusory and unenforceable.[2]

STATEMENT OF THE CASE

Invoking 28 U.S.C. §1331, respondents filed this action in the United States District Court for the Eastern District of

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[1]Pursuant to Rule 36 of the Rules of this Court, the parties have consented to the filing of this brief. Their letters of consent are set forth in the Appendix to this brief.

[2]This case does not concern any claims for individual benefits under part B of Medicare. The AMA does not dispute that such claims can properly be excluded from the federal courts.

spondents' challenge to the lawfulness of 42 C.F.R. §405.504. Section 1395ff precludes judicial review only of an individualized "determination of the amount of benefits" under part B. This case does not involve an individualized amount determination. Indeed, it does not constitute a specific claim for benefits at all.

Rather, this action is a challenge to the Secretary's statutory authority to promulgate a regulation of sweeping applicability. Nothing in the language or legislative history suggests that §1395ff is meant to preclude such a challenge. In fact, this Court has itself exercised jurisdiction over a similarly broad challenge to a procedure under Part B of Medicare. *Schweiker* v. *McClure*, 456 U.S. 188 (1982).

Second, §405(h), as incorporated into the Medicare Act by 42 U.S.C. §1395ii, does not preclude jurisdiction over this action. The second sentence of §405(h) bars direct review of findings of fact or decisions made by the Secretary after a hearing. It does not apply to the challenged regulation because that regulation was not issued after a hearing by the Secretary. In fact, Part B of Medicare does not provide for any hearing by the Secretary.

The third sentence of §405(h) also does not preclude jurisdiction over this action. By its terms, the third sentence bars only those actions in which a plaintiff seeks to "recover" on a "claim" for benefits. Respondents in this case seek neither to "recover" on a "claim" for benefits nor to obtain a ruling that is tantamount to such a result.

In any event, the third sentence of §405(h) has never been applied by this Court to preclude federal court jurisdiction under §1331 where there was no alternative route to judicial review. The government acknowledges that respondents have no such alternative route here. Since §405(h) applies to Medicare only "as applicable" under 42 U.S.C. §1395ii, it should not be made applicable to bar this action under 28 U.S.C. §1331 where no alternative route to review exists.

B.

To the extent that §§1395ff and 405(h) are applied to preclude judicial review of the lawfulness of 42 C.F.R. §405.504, they are unconstitutional for two reasons. First, their application in this case would violate the due process clause of the Fifth Amendment. That clause requires judicial review where, as here, (1) important interests are at stake, (2) there is a substantial likelihood that judicial review will be able to redress erroneous administrative action, and (3) such review will not produce a significant administrative or judicial burden. *See*, *Mathews* v. *Eldridge*, 424 U.S. 319 (1976).

Second, the application of §§1395ff and 405(h) to preclude judicial review of this case would violate the doctrine of Separation of Powers embodied in the Constitution. To the extent that these statutes are invoked to prevent the judiciary from enforcing the Secretary's adherence to his statutory mandate, they effectively create an open-ended delegation of legislative power to the Executive Branch. The Constitution does not permit this result.

ARGUMENT

I. THE MEDICARE ACT DOES NOT FORECLOSE JUDICIAL CONSIDERATION OF RESPONDENTS' CHALLENGE TO THE SECRETARY'S STATUTORY AND CONSTITUTIONAL AUTHORITY TO PROMULGATE A REGULATION UNDER PART B OF MEDICARE

The government argues that the courts have no jurisdiction under 28 U.S.C. §1331 to hear respondents' challenge to 42 C.F.R. §405.504. The government does not suggest any alternative route by which respondents may obtain judicial review of the statutory and constitutional validity of this regulation. Instead, it effectively concedes that there is none.[3]

[3]The supposed preclusion of judicial review extents to state courts. It is the government's position that §405(h) precludes review of §405.504 by "any tribunal." (Pet. Brief, at 34). Similarly, the implied preclusion advocated by the government under §1395ff would extend to all courts.

This Court has long held, however, that there is an exceedingly strong presumption against construing any statute so as to preclude judicial review. "[O]nly upon a showing of 'clear and convincing evidence' of a contrary legislative intent should the courts restrict access to judicial review." *Abbott Laboratories* v. *Gardner*, 387 U.S. 136, 141 (1967). *Accord*, *Dunlop* v. *Bachowski*, 421 U.S. 560, 567 (1975) (there is a "strong presumption that Congress did not mean to prohibit all judicial review" of decisions by the Secretary of Labor).

Thus, this Court will not lightly infer that "Congress does not intend judicial protection of rights it confers against agency action taken in excess of delegated powers." *Leedom* v. *Kyne*, 358 U.S. 184, 190 (1958). Indeed, for Congress to withhold judicial consideration of such issues would be "extraordinary" and would raise a "serious constitutional question of the validity of the statute as so construed." *Weinberger* v. *Salfi*, 422 U.S. 749, 762 (1975). *Accord*, *Johnson* v. *Robison*, 415 U.S. 361, 366-67 (1974). *Cf. Northern Pipeline Co.* v. *Marathon Pipe Line Co.*, 450 U.S. 50, 69-70 n.13 (1982) (plurality opinion). In light of the fundamental presumption in favor of judicial review, the Secretary's statutory arguments must fail.

A. Jurisdiction Is Not Impliedly Precluded By 42 U.S.C. §1395ff

1. This Court's Decision In The Erika Case Does Not Support Implied Preclusion Under §1395ff

Initially, the government argues that 42 U.S.C §1395ff forecloses judicial review of §405.504. Section 1395ff does not expressly preclude judicial review. It simply provides a review procedure for "determination of the amount of benefits under Part A" of Medicare. 42 U.S.C. §1395ff(a). In *United States* v. *Erika, Inc.*, 456 U.S. 201 (1982), however, this Court held that

the absence of an analogous provision for "determination of the amount of benefits" under Part B constitutes "persuasive evidence that Congress deliberately intended to foreclose further review of such claims." *Id.* at 208.

The government argues that *Erika* directly controls this case (Pet. Brief, at 30). Unlike this case, however, *Erika* concerned only an individual claim for specific benefits. Its holding is inapplicable to this general challenge to the validity of a regulation.

The plaintiff in *Erika*, a distributor of kidney dialysis supplies, was dissatisfied with the amount of reimbursement under Part B that it had received from its local Medicare carrier. *Id.* at 204-05. After unsuccessfully seeking review by the carrier of its claim for benefits, the distributor filed an action in federal court seeking additional payment. The case ultimately reached the Supreme Court on the issue of jurisdiction.

This Court carefully defined the question as whether the district court had "jurisdiction to review determinations by private insurance carriers of the *amount of benefits* payable under Part B of the Medicare statute." 456 U.S. at 202 (emphasis supplied). The Court answered this question in the negative. It held that the Medicare statute does not authorize review of "adverse hearing officer determinations of the amount of Part B benefits." *Id.* at 206.

Neither the holding nor the reasoning of *Erika* applies here. First, this case does not involve a determination of the amount of benefits payable to a claimant or a review of the amount of a specific Part B award. Respondents do not seek any past or prospective reimbursement. Nor do they seek that any "amount" be specifically "determined." Rather, they challenge the substantive validity of sweeping regulatory action generally authorizing

separate prevailing charge screens.[4] Accordingly, the narrow holding of *Erika* regarding individual determinations of the amount of benefits is inapplicable to this case. *See*, *Hatcher* v. *Heckler*, 772 F.2d 427, 430 (8th Cir. 1985) (holding that *Erika* and §1395ff do "not preclude judicial review of Part B claims where they go beyond mere disputes over amounts owed"); *College of American Pathologists* v. *Heckler*, 734 F.2d 859, 862-63 (D.C. Cir. 1984); *National Association of Patients on Hemodialysis* v. *Heckler*, 588 F.Supp. 1108, 1116 (D.D.C. 1984).

Second, the statutory language of §1395ff, which was the starting point for the Court's analysis in *Erika*, provides no support for an implied preclusion of respondents' challenge. The language of §1395ff does imply preclusion of specific part B amount determinations by its reference to a "determination of the amount of benefits under part A." In stark contrast, §1395ff contains no reference whatsoever to actions regarding the broad regulatory framework adopted by the Secretary. In the absence of such a reference, no basis for preclusion can be implied.

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[4]Unlike the present action, *Erika* did not involve a challenge to the lawfulness of any regulation or other generalized policy of the Secretary. The substantive dispute in *Erika* was whether the local carrier had properly applied the Secretary's admittedly permissible "prevailing charge" definition in calculating the distributor's "reasonable charge" under Medicare. *Erika*, *supra*, 456 U.S. at 204 n. 2. This disputed application had no significance with respect to anyone except the complaining distributor because the distributor "was virtually the only provider of dialysis supplies within [the carrier's] locality." *Id.*

Even as to the distributor, the materiality of the disputed application was unclear since the carrier was not bound by any "prevailing charge" calculation but retained flexibility to consider "[o]ther factors that may be found necessary and appropriate with respect to a specific item or service to use in judging whether the charge is inherently reasonable." 20 C.F.R. §405.502(a)(4). Moreover, the government is mistaken in claiming that plaintiff in *Erika* challenged instructions issued by the Secretary. (Pet. Brief, at 32). The plaintiff in *Erika* questioned only whether any such instructions were in effect. The Court of Appeals found that none were. *Erika, Inc.* v. *United States*, 634 F.2d 580, 590 (Ct. Cl. 1980).

Third, nothing in the legislative history of §1395ff suggests that Congress intended to preclude broad challenges to the lawfulness of regulations adopted by the Secretary. To the contrary, that history demonstrates that the concern of Congress was to preclude review of individual *amount* determinations under Part B. *Erika*, *supra*, 456 U.S. at 209 n.11. "[P]ayments under the Part B program generally were expected to be smaller than those under the primary Part A program." Congress wanted " 'to avoid overloading the courts with quite minor matters' " regarding trivial adjustments to already small amounts. *Id.* at 208-09 (quoting remarks of Senator Bennett, 118 Cong. Rec. 33992 (1972)).

A challenge to the Secretary's authority to promulgate a regulation of general applicability can hardly be characterized as a minor matter. As the D.C. Circuit has observed:

> "The legislative history cited in *Erika* only reveals an intent to preclude review of Part B *amount* determinations. . . . Accordingly, we reject the Secretary's argument that Congress intended to preclude judicial review of the regulations challenged here."

College of American Pathologists, *supra*, 734 F.2d at 863 (emphasis in original). *Accord*, *National Association of Patients on Hemodialysis*, *supra*, 588 F.Supp. at 1116. Indeed, it would be wholly incongruous to impute such a judgment to the same Congress that considered an individual benefit amount determination under Part A worthy of judicial review. 42 U.S.C. 1395ff.[5]

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[5]The government also cites *Heckler* v. *Ringer*, 466 U.S. 602 (1984), in support of its argument that §1395ff bars constitutional and statutory claims regarding the lawfulness of regulations under Part B. As discussed below, pp. 16-17, *infra*, *Ringer* is inapposite because, unlike the present case, it involved a claim for benefits. In any event, the scope of §1395ff was neither at issue nor decided in *Ringer* because the respondents did not press their claims for Part B benefits. This Court viewed *Ringer* "as involving only respondents' Part A claims." 80 L.Ed. 2d at 632 n. 4.

2. The Government's Attempt To Expand The Preclusive Effect Of §1395ff Is Without Merit

The government argues that §1395ff precludes review not only of a particular "determination of the amount of benefits" but of any matter "*bearing* on the calculation of the amount of benefits under Part B." (Pet. Brief, at 25). Neither the language nor the legislative history of §1395ff supports this expansive standard. In fact, this Court's application of §1395ff directly undercuts the government's position.

As this Court has observed, the language of the statute is the "lodestar" for any determination of the preclusive effect of §1395ff. *Erika*, *supra*, 456 U.S. at 206. The relevant language refers only to a "determination of the amount of benefits." It does not extend to matters which might have a "bearing on the calculation of the amount of benefits under Part B" (Pet. Brief, at 25). Thus, the preclusion standard advocated by the government lacks any foundation in the language of §1395ff.

Second, the legislative history does not demonstrate any Congressional intent to adopt a broadened scope of preclusion under §1395ff. The government bases its argument that judicial review of all determinations "bearing on" or "concerning" the amount of benefits under Part B is precluded by §1395ff on a single sentence contained in S. Rep. No. 404, 89th Cong., 1st Sess., 54-55 (1965):

> "Under the supplementary plan [Part B] carriers, not the Secretary, would review beneficiary complaints regarding the amount of benefits, and the bill does not provide for judicial review of a determination concerning the amount of benefits under Part B where claims will probably be for substantially smaller amounts than under Part A."

While this Report does use the word "concerning," it is clear from the context that the word is not used as a synonym for

"affecting." It is used instead as a synonym for "of" or "about." This interpretation is confirmed by the fact that the statute uses the word "of" rather than "concerning," *i.e.*, "determination *of* the amount of benefits." 42 U.S.C. 1395ff(a).

The observation of the D.C. Circuit is most accurate:

> "Nor does the Secretary direct our attention to, or claim the existence of, anything evincing the requisite congressional intent. Instead, the Secretary papers over this critical deficiency by arguing that since both *Erika* and this case may ultimately affect part B payments, the availability of judicial review should be the same in both situations. Yet, the Secretary points to no supporting legislative history for her position."

College of American Pathologists, *supra*, 734 F.2d 859 at 863. The legislative history simply does not indicate that Congress ever considered effecting a preclusion as broad as the government now advocates.

Finally, the government's attempt to read § 1395ff to preclude judicial review of any matter "bearing on" Part B benefits is directly contradicted by the decision of this Court in *Schweiker* v. *McClure*, 456 U.S. 188 (1982). In *McClure*, three Medicare beneficiaries who had been denied full reimbursement on their Part B claims brought an action claiming that their awards were inadequate. They challenged on due process grounds the alleged lack of impartiality of the carrier's hearing officers.

This challenge certainly "concerned" the amount of benefits received by the plaintiffs. Moreover, it was possible to characterize plaintiffs' claims as " 'motivated in part by a desire for increased payment.' " *See*, Pet. Brief, at 9. Yet this Court exercised jurisdiction over these claims—on the same day as it decided *Erika*. Under the government's "bearing on" standard, the exercise of jurisdiction would have been improper. In short, there is

absolutely no basis for the Secretary's effort to expand the preclusive effect of §1395ff.[6]

B. Jurisdiction Is Not Explicitly Precluded By 42 U.S.C. §405(h) As Made Applicable To Medicare By 42 U.S.C. §1395ii

The government also contends that 42 U.S.C. §405(h), as made applicable to the Medicare program by 42 U.S.C. §1395ii, precludes jurisdiction of respondents' statutory and constitutional challenge to §405.504. The government suggests that the second and the third sentence of §405(h) each independently accomplishes this result. Neither of these sentences, however, bars the assertion of jurisdiction pursuant to 28 U.S.C. §1331.

1. The Second Sentence Of §405(h) Does Not Bar Jurisdiction Here

Initially, the government relies on the second sentence of §405(h). Pet. Brief, at 34. That sentence must be read in conjunction with the first sentence of §405(h). The precise language of the two sentences is as follows:

> "The findings and decisions of the Secretary *after a hearing* shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the Secretary shall be reviewed by any person, tribunal, or governmental agency except as herein provided." (emphasis supplied)

Read in context, the "findings of fact or decision" referred to in the second sentence of §405(h) clearly are those made by the Secretary "after a hearing."

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[6]The Secretary also argues that the explicit preclusion of review of the Secretary's "establishment of diagnosis related groups [and] of the methodology for the classification of discharges within such groups," 42 U.S.C. §1395ww(d)(7)(B), somehow indicates a similar Congressional intent regarding prevailing charge regulations. Pet. Brief, at 27-28. All that the adoption of §1395ww(d)(7)(B) demonstrates, however, is that Congress speaks directly and clearly when it wishes to preclude review of regulations adopted by the Secretary. The absence of any similarly clear pronouncement regarding general regulations under Part B of Medicare thus indicates the absence of any Congressional intent to achieve such a result.

There has not been any "hearing" before the Secretary in connection with the issues involved in this action. Indeed, no such hearing is available. The only administrative hearing of any sort available under Part B of Medicare is that provided by 42 U.S.C. §1395u(b)(3)(C). That hearing is before a Medicare carrier—not the Secretary.

The government attempts to equate a hearing by the carrier with a hearing by the Secretary (Pet. Brief, at 34). It would thereby read §405(h) as if it referred to "findings and decisions of the [carrier] after a hearing." But the legislative history clearly reveals that Congress considered hearings before the Secretary and hearings before the carriers to be two different things. It drafted the statute with an eye to this distinction.

As stated in the Senate Report on the original Medicare Act (S. Rep. No. 404, 89th Cong., lst Sess., 54-55 (1965):

> "Under the supplementary plan [Part B] *carriers, not the Secretary*, would review beneficiary complaints regarding the amount of benefits . . ." (emphasis supplied)

See also H. R. Rep. No. 92-1605, 92nd Cong., 2nd Sess., 61 (1972) (stating that "there is no authorization for an appeal *to the Secretary*" from carrier determinations "on matters solely involving amount of benefits under Part B") (emphasis supplied). Thus, "[b]y its own terms, §405(h) is inapplicable to this [part B] case, which involves no findings of fact nor any decision by the Secretary on a claim for benefits." *National Association of Patients on Hemodialysis*, *supra*, 588 F.Supp. at 1117. *Accord*, *Colonial Penn Ins. Co.* v. *Heckler*, 721 F.2d 431, 439 (3rd Cir. 1983).[7]

[7]Moreover, the Secretary regards the two kinds of hearings as very different. The Carrier's Manual compiled by the Secretary prevents the carriers from even rendering a "decision" regarding the lawfulness of a regulation promulgated by the Secretary. Section 12016 of the Manual prohibits use of "hearing decisions as a vehicle for commenting upon the legality, constitutional or otherwise, of any provision of the act or regulations relevant to the Medicare Program."

The limited scope of the second sentence of § 405(h) is explained by the critical difference between hearings before the carrier and those before the Secretary. In particular, a route of review from hearings by the Secretary lies through 42 U.S.C. § 405(g) as incorporated into Medicare by 42 U.S.C. §1395ii. Therefore, the second sentence of §405(h) merely operates as a requirement of administrative exhaustion. *See, Heckler* v. *Ringer*, *supra*, 466 U.S. 602; *Weinberger* v. *Salfi*, 422 U.S. 749, 757 (1975). By contrast, no such review of carrier hearings under Part B is available through § 405(g). Not surprisingly, the Secretary is unable to cite a single case in which the second sentence of § 405(h) has been applied to bar a general challenge to a regulation under part B.

2. The Third Sentence Of § 405(h) Does Not Bar Jurisdiction Here

Alternatively, the government relies upon the third sentence of § 405(h) as a bar to judicial review of respondents' statutory and constitutional challenge. That sentence is inapplicable for two reasons. First, the third sentence bars only those actions brought "to *recover* on any *claim* arising under this subchapter." 42 U.S.C. § 405(h) (emphasis supplied). Respondents in this case do not seek "to recover" on any "claim" or to achieve a result that is tantamount to recovery on a claim.

Second, § 405(h) does not apply directly to Medicare. Instead, under 42 U.S.C. § 1395ii, it is incorporated into Medicare only "as applicable." The third sentence of § 405(h) is not applicable to Medicare to the extent that it would bar challenges under § 1331 to the lawfulness of the Secretary's regulations in the absence of any alternative route to judicial review.

a.

The language "to recover on any claim" as used in the third sentence of § 405(h) suggests an action brought to establish an in-

dividual's entitlement, either past or prospective, to specific reimbursement. *See National Association of Patients On Hemodialysis*, *supra*, 588 F.Supp. at 1116-1118. Respondents brought this action seeking only to invalidate the maintenance of separate prevailing charge screens. They have not sought a specific amount of reimbursement or even a ruling that will entitle them to a specific amount. Therefore, their action is not of the sort to which the language of the third sentence of §405(h) applies.

The mere fact that an action may tangentially affect reimbursement amounts does not suffice to make it a "claim" within the meaning of 42 U.S.C. §405(h). *See*, *Bio-Medical Applications of Providence, Inc.* v. *Heckler*, 593 F.Supp. 1233, 1236 (D.D.C. 1984) ("If defendants' argument were to be accepted, it would mean that any procedural dispute which had even the most tangential affect on reimbursement amounts would be precluded from judicial review, thus in effect exempting the entire Medicare area from the provisions of the APA"). Instead, the "claim" referred to in the third sentence of §405(h) is a claim for payment of an entire amount of benefits, *i.e.*, of the sort which can and must be presented to the Secretary. *See Heckler* v. *Ringer*, *supra*, 466 U.S. 602, 80 L.Ed.2d at 636-37, 640 (indicating that a "claim" can either be for "immediate payment of benefits" or "to establish a right to future payment"); *Mathews* v. *Eldridge*, 424 U.S. 319, 326-329 (1976).

Challenges which might merely affect benefits cannot be presented in isolation to the Secretary because they do not constitute the requisite full "claim for payment." *See Colonial Penn Ins. Co.*, *supra*, 721 F.2d at 438. *Cf.* 42 U.S.C. §1395u(b)(3)(C) (carrier hearings must be directed at requests for payment). Accordingly, such partial challenges, unaccompanied by any request for payment of the benefit amount or to establish a right to such payment, do not constitute "claims" for purposes of §405(h).

Even if respondents' broad regulatory challenge could somehow be characterized as a "claim" under §405(h), this ac-

tion is not one "to recover" anything. If respondents ultimately prevail, they will be entitled only to a reformulation of the current prevailing charge screen system. The construction and level of the new screen remain within the Secretary's lawful discretion. See Pet. App. 14a-15a.

Thus, as the Court of Appeals concluded, "[w]hile the eventual result of this suit *may* cause an increase in amounts of reimbursement, *that does not necessarily follow.*" Pet. App. 8a (emphasis supplied). On the contrary, "a reduction in reimbursement could occur." *Id.* It is not possible to characterize such a result as a "recovery" on a "claim" without resorting to "a nihilistic view of linguistic interpretation [which] . . . hardly provides an adequate basis for statutory construction." *Lindahl* v. *Office of Personnel Management*, U.S. , 105 S.Ct. 1620, 53 U.S.L.W. 4371, 4379 (1985) (White, J., dissenting.)

For these reasons, the wording of the third sentence of §405(h) demonstrates the inapplicability of that provision. The government, however, attempts to sidestep this language by purporting to find authority for its position in this Court's decision in *Ringer*. Specifically, the government first labels respondents' challenge as "procedural" and then argues that *Ringer* bars all "procedural" challenges "arising under" the Social Security Act (Pet. Brief, at 36-37).

Ringer stands for no such sweeping proposition. That case involved nothing more than four claims for reimbursement for a particular surgical procedure. Three of these claims were retroactive. One was prospective.

This Court recognized that if the relief requested in *Ringer* were granted, "only essentially ministerial details will remain before respondents would receive reimbursement." 80 L.Ed.2d at 636. It stated:

> "We agree with the District Court, however, that those claims are inextricably intertwined with respondents' claims

> for benefits. Indeed the relief that respondents seek to redress their supposed 'procedural' objections is the invalidation of the Secretary's current policy and a 'substantive' declaration from her that the expenses of BCBR surgery are reimbursable under the Medicare Act."

Id. at 635. Thus, contrary to the government's position, *Ringer* did not hold that all procedural challenges to Medicare regulations are barred by §405(h). It held only that those procedural challenges which are tantamount to a claim for benefits are so barred.[8]

Any other holding would have conflicted with both the "to recover" language of §405(h) and with the decision of this Court in *Schweiker* v. *McClure*, 456 U.S. 188 (1982). There, the Court exercised jurisdiction under 28 U.S.C. §1331 over a purely procedural challenge which was entirely collateral to any claim for benefits. *Cf. Mathews* v. *Eldridge*, 424 U.S. 319, 330 (1976) (recognizing that some procedural claims can be entirely collateral to a substantive claim of entitlement).

This case is very different from *Ringer*. It does not involve a challenge "inextricably intertwined" with individuals' claims to recover benefits. Rather, it is similar to *McClure* in that no claim for benefits has been made and no substantive "recovery" is necessarily entailed. In summary, neither the language of the third sentence of §405(h) nor this Court's decisions provide any support for applying that sentence to preclude the exercise of jurisdiction in this case.

b.

There is another reason that the third sentence of §405(h) does not foreclose jurisdiction in this case. Section 405(h) does not

[8] *Weinberger* v. *Salfi*, 422 U.S. 749 (1975), similarly involved a claim to recover benefits. The named plaintiffs explicitly sought recovery of "the amount of benefits to which plaintiffs became entitled." *Id.* at 755.

apply directly to Medicare. It is incorporated into Medicare by 42 U.S.C. §1395ii only "as applicable." "[A] statute incorporated into another 'as applicable' will be read in such a manner as will give form and effect to the statute into which it is incorporated." *St. Louis University* v. *Blue Cross Hospital Service,* 537 F.2d 283, 292 (8th Cir.), *cert. denied,* 429 U.S. 977 (1976).

As enacted as part of Title II of the Social Security Act, §405(h) does not, and was never intended to, cut off judicial review of the lawfulness of the Secretary's regulations. *See* H.R. Rep. No. 728, 76th Cong. lst Sess. at 43-44 (1939). Rather, 405(h) merely reroutes such challenges through §405(g). *See Weinberger* v. *Salfi,* 422 U.S. 749, 762-63 (1975). Similarly, as applied to Medicare through §1395ii, §405(h) should be deemed applicable only to the extent that it leaves intact some route for obtaining judicial review of challenges to the lawfulness of the Secretary's regulations.

Because 28 U.S.C. §1331 provides the only available path to judicial review here, its assertion as a predicate for jurisdiction should not be precluded by §405(h). Rather, as applied to this case, that section should be deemed incorporated by §1395ii *mutatis mutandis.* As one court has noted, "Congress, by incorporating section 405(h) into the Medicare Act to the extent applicable, did not intend to preclude judicial review of claims for which no alternative form of judicial review was available." *National Association of Home Health Agencies* v. *Schweiker,* 690 F.2d 932, 941 (D.C. Cir. 1982), *cert. denied,* 459 U.S. 1204 (1983).

The government completely ignores the crucial fact that §405(h) does not apply directly to Medicare. Instead, it relies almost exclusively on this Court's decisions in *Heckler* v. *Ringer,* 466 U.S. 602 (1984), and *Weinberger* v. *Salfi,* 422 U.S. 749 (1975). Those decisions differ fundamentally from the present case, however, in that the application of §405(h) left plaintiffs in those cases with a route to judicial review.

All the plaintiffs in *Ringer,* including the one who had not yet undergone surgery, had the ability eventually to have their claims brought for review before a court. In fact, the *Ringer* decision was predicated on not permitting the plaintiffs to circumvent the Medicare Act's carefully crafted route to judicial review. This Court concluded that "all aspects of respondents' claims for benefits should be channeled first into the administrative process which Congress has provided for the determination of claims for benefits." 80 L.Ed.2d at 635.

Similarly, when applying §405(h) in *Salfi,* this Court emphasized that the statutory scheme of Title II does not foreclose all judicial review but simply requires that actions "be brought under jurisdictional grants contained in the Act." 422 U.S. at 762. Those alternative jurisdictional grants ultimately allowed for review in *Salfi.* Indeed, the Court remarked that the elimination of all judicial consideration would have been so "extraordinary," that " 'clear and convincing' evidence would be required before we ascribe such intent to Congress." *Id.*

In contrast to *Ringer* and *Salfi,* respondents here have no route to judicial review if jurisdiction under §1331 is foreclosed. 42 U.S.C. §1395ii provides the flexibility to take into account this difference. Accordingly, in order to avoid the constitutional problems touched upon in *Salfi* and discussed at length below, §405(h) should not be deemed incorporated into §1395ii so as to preclude judicial review of respondents' statutory and constitutional challenge to the Secretary's regulation.

II. JUDICIAL REVIEW OF RESPONDENTS' CHALLENGE TO THE SECRETARY'S REGULATION IS REQUIRED BY THE CONSTITUTION

As detailed above, §§1395ff and 405(h) do not bar the assertion of jurisdiction in this case pursuant to 28 U.S.C. §1331. However, to the extent that they do, they are unconstitutional. Specifically,

their application in the circumstances of this case violates due process requirements and the constitutional doctrine of Separation of Powers.[9]

A. Due Process Requires Judicial Review Of Respondents' Challenge To The Secretary's Regulation.

This Court has recognized that the requirements of due process apply to Medicare. *Schweiker* v. *McClure,* 456 U.S. 188 (1982). *Cf. Weinberger* v. *Salfi,* 422 U.S. 749, 768-69 (1975). It has also recognized that "under certain circumstances, the constitutional requirement of due process is a requirement of judicial process." *Crowell* v. *Benson,* 285 U.S. 22, 87 (1932) (Brandeis, J., dissenting). *Cf. Northern Pipelines Co.* v. *Marathon Pipe Line Co.,* 458 U.S. 50, 69-70 n. 23 (1982) (plurality opinion) ("when Congress assigns these matters to administrative agencies . . . it has generally provided, and we have suggested that it may be required to provide, for Art. III judicial review"). Respondents' challenge to the Secretary's authority to promulgate a sweeping regulation is a circumstance in which judicial process is constitutionally required.

This conclusion is dictated by the three factors which this Court has identified as relevant in determining "the specific dictates of due process" in the context of an administrative program:

> "First, the private interest that will be affected by the official action; second, the risks of an erroneous deprivation of such interest through the procedures used, and the probable value, if any, of additional or substitute procedural safeguards; and finally, the Government's interest, including the function involved and the fiscal and administrative burdens that the additional or substitute procedural requirement would entail."

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[9]This Court has noted but not decided the question of the constitutionality of the preclusion of judicial review by §§1395ff and 405(h). *Erika, supra,* 456 U.S. at 211 n.14.

Mathews v. *Eldridge*, 424 U.S. 319, 335 (1976). *Accord*, *McClure*, *supra*, 456 U.S. at 193-94. Application of these factors demonstrates the appropriateness of judicial review in this case.

First, the interests implicated by the Secretary's promulgation of the challenged regulation are substantial. This Court has previously assumed that private interests in Part B payments are " 'considerable,' though 'not quite as precious as the right to receive welfare or social security benefits.' " *McClure*, *supra*, 456 U.S. at 198. In any event, as the district court found, the regulation challenged here "tends to influence the patient's choice of a physician" (Pet. App. 30a). And a patient's choice of physician is a matter of fundamental importance. *See*, *Doe* v. *Bolton*, 410 U.S. 179, 219-220 (1973) (Douglas, J., concurring) (discussing Fourteenth Amendment protection of right "to seek out a physician of one's choice"). *See also*, 42 U.S.C. §1395a (freedom of choice of physician guaranteed by Medicare Act).

More than private interests are implicated by this case. The question of whether the Secretary has exceeded delegated authority in promulgating a regulation implicates public interests of the most fundamental sort. Thus, both public and private interests of major importance are at stake here.

Second, there is a substantial likelihood that judicial review will be of value in correcting any erroneous legal assessment by the Secretary embodied in the challenged regulation. Judicial review will enable the courts to determine whether the challenged regulation accords with the requirements of 42 U.S.C. §1395u(b)(3) and of the constitution. Courts have always been considered the superior adjudicators of such legal questions. " '[W]here the only or principal dispute relates to the meaning of the statutory term' . . . the controversy presents issues on which courts, and not [administrators], are relatively more expert." *Barlow* v. *Collins*, 397 U.S. 159, 166 (1970), quoting *Hardin* v. *Kentucky Utilities Co.*, 340 U.S. 1, 14 (Harlan, J., dissenting).

See Califano v. *Sanders*, 430 U.S. 99, 109 (1977); *Wayne State Univ.* v. *Cleland*, 590 F.2d 627, 631-32 (6th Cir. 1978).

To be sure, an agency's interpretations of statutory provisions have always been given judicial consideration. *See, e.g., NLRB* v. *Bell Aerospace Co.*, 416 U.S. 267, 274-75 (1974). An agency has never been thought to possess such expertise, however, as to justify abdication of judicial oversight. *See, Skidmore* v. *Swift & Co.*, 323 U.S. 134, 140 (1944); *National Ass'n of Home Health Agencies*, *supra*, 690 F.2d at 940-41 (finding that review of actions implementing Medicare Act did not intrude upon area of agency expertise). Accordingly, judicial review of respondents' facial challenge to the lawfulness of the Secretary's regulation is warranted because it significantly increases the probability of correcting any error. Indeed, both the district court and the Court of Appeals concluded that such an error had been made. *See*, pp. 2-3, *supra*.

For due process purposes, respondents' challenge to §405.504 must be contrasted with a challenge to the Secretary's application of valid statutory and regulatory standards to a particular set of facts in order to make a factual determination as to the "amount of benefits" due an individual. The latter case involves issues within the sphere of administrative expertise. Courts are not particularly well suited to make such specialized factual determinations. Consequently, there is a substantially diminished likelihood that judicial review would serve to correct any administrative error. *Cf. Schweiker* v. *McClure*, 456 U.S. 188, 198-200 (1982) (holding that due process does not require review of benefit determinations).

The lack of any judicial review for individualized claims of erroneous factual determinations may thus be consonant with due process. That, however, is not the nature of the claim here. Respondents' challenge is not based on individualized factual determinations. It is predicated on the Secretary's lack of authority to promulgate a regulation.

Finally, no substantial costs would be imposed by a requirement of judicial review of actions which challenge the Secretary's statutory and constitutional authority to promulgate a regulation of general applicability. Such actions do not threaten to flood the federal courts with review of individual benefit determinations. On the contrary, a holding that due process requires the exercise of jurisdiction here will apply only to the small number of cases in which there is a colorable challenge to the lawfulness of a regulation and in which there is no alternative route to judicial review.

It is both desirable and cost-effective to resolve questions of broad applicability and repeated relevance in a single judicial proceeding. *Cf. Johnson* v. *Robison*, 415 U.S. 361, 373 (1974) (finding that constitutional challenges to veterans' benefits legislation "cannot be expected to burden the courts by their volume"). As one recent commentator has concluded, "permitting review only when plaintiffs argue that a particular statutory or administrative standard is itself invalid would not result in a costly flood of litigation, because the validity of a standard can be readily established, at times even in a single case." Note, *Congressional Preclusion of Judicial Review of Federal Benefit Disbursement: Reasserting Separation of Powers*, 97 Harv.L. Rev. 792 (1984).

In short, the interests at issue here are important. There is a substantial likelihood that the judiciary will be able to redress any erroneous determination of those interests. Moreover, the exercise of jurisdiction does not threaten to inundate the courts or to create any other administrative burden. Accordingly, due process requires that §§ 1395ff and 405(h) be declared unconstitutional to the extent that they are applied to preclude judicial review of this case.

B. The Constitutional Scheme Of Separation Of Powers Requires Judicial Review Of Respondents' Challenge To The Secretary's Regulation

Judicial review of whether the challenged regulation exceeds the authority delegated to the Secretary under the Medicare Act

is also required by the constitutional doctrine of Separation of Powers. Without judicial review, any Congressional restriction on the exercise of authority by the Executive Branch under the Medicare Act would be illusory. As the Court of Appeals correctly noted, "[t]he Secretary apparently would have unbridled discretion to promulgate any regulation he chose." Pet.App. 10a.

This Court has required that any congressional delegation of authority provide "the recipient of that authority with an 'intelligible principle' to guide the exercise of the delegated discretion." *Industrial Union Dept.* v. *American Petrol. Inst.*, 447 U.S. 607, 686-87 (1980) (Rehnquist, J. concurring). This requirement ensures that "important choices of social policy are made by Congress." *Id.* at 685. It ensures that Congress does not abdicate its role in the constitutional scheme. Thus, an "open-ended grant" of legislative power is constitutionally defective. *Id.* at 646 (plurality opinion). *Accord*, *Schechter Poultry Corp.* v. *United States*, 295 U.S. 495, 539 (1935).

As this Court has recognized, judicial review provides "safeguards against statutory or constitutional excess." *American Power & Light Co.* v. *SEC*, 329 U.S. 90, 106 (1946). Such review is an essential element in ensuring that the Executive Branch remains bound by the limiting principles that Congress purports to provide. *See*, *e.g.*, *Immigration & Naturalization Service* v. *Chadha*, 462 U.S. 919, 953 n.16 (1983) (courts "can always . . . enforce adherence to statutory standards"); *Yakus* v. *United States*, 321 U.S. 414, 425 (1944) (the "concern of courts is to ascertain whether the will of Congress has been obeyed"). *Cf. Leedom* v. *Kyne*, 358 U.S. 184, 190-91 (1958). Indeed, absent judicial review and enforcement, it would make no difference whether or not a congressional grant of authority contained any guiding "intelligible principle." The recipient of the authority would be free to contravene any such principle with impunity.

Moreover, corrective congressional oversight in such a situation cannot be presumed. Rather, the Judicial Branch must

maintain the separation of powers between the Executive and the Legislative. As one recent commentator has concluded:

> "If separation-of-powers doctrine requires that delegation of authority be accompanied by limits—legislative or administrative—to protect against executive arbitrariness, it follows that separation-of-powers doctrine must also prohibit Congress from precluding judicial enforcement of those limits. . . . The availability of judicial review can therefore be seen as a necessary correlate of the procedural and substantive limits placed on the authority of the executive."

Note, *Congressional Preclusion of Judicial Review of Federal Benefit Disbursement: Reasserting Separation of Powers*, Harv.L.Rev. 786-787 (1984).

In sum, if, as the government contends, §§ 1395ff and 405(h) preclude all judicial review of the question of whether the Secretary exceeded his statutory power in promulgating a regulation, these sections remove the judiciary as the primary check against unlawful delegation of legislative authority to the Executive Branch. In this respect, they upset the constitutional scheme of Separation of Powers. They are therefore unconstitutional as applied.

CONCLUSION

For the reasons stated above, the judgment of the Court of Appeals should be affirmed.

Respectfully submitted,

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December 26, 1985

December 6, 1985

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Re: *Margaret M. Heckler, Secretary of Health and Human Services,* et al. v. *Michigan Academy of Family Physicians,* et al., No. 85-225

Dear Mr. Graham:

As requested in your letter of December 4, 1985, I hereby consent to the filing of a brief amicus curiae on behalf of the American Medical Association in this case.

Sincerely,

CHARLES FRIED
Solicitor General

December 19, 1985

David F. Graham
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Re: *Margaret M. Heckler, Secetary of Health and Human Services,* et al. vs. *Michigan Academy of Family Physicians,* et al. No. 85-225

Dear Mr. Graham:

On behalf of respondents Michigan Academy of Family Physicians, Lester Webb, Charles Farber, Glenn House and Carol A. Diedrich, I hereby consent to the filing of a brief *amicus curiae* in this case on behalf of the American Medical Association.

Very truly yours,

ALAN G. GILCHRIST